IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B. CARRIE G., JOSHUA M., MEAGAN A. and ERICA A., by their next friend, L.A.; DUSTN P. by his next friend, LINDA C. BAYLIS. By her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,	)
Plaintiffs,	)
v.	)NO. 3-98-0168)Judge Nixon
NANCY MENKE, Commissioner, Tennessee Department of Health; THERESA CLARKE, Assistant Commissioner Bureau of TennCare; and GEORGE HATTAWAY, Commissioner Tennessee Department of Children's Services	)
Defendants.	)

JANUARY 2001 SEMI-ANNUAL PROGRESS REPORT

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
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JOHN B. CARRIE G., JOSHUA M., MEAGAN A. and ERICA A., by their next friend, L.A.; DUSTN P. by his next friend, LINDA C. BAYLIS. By her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,	)
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JANUARY 2001 SEMI-ANNUAL PROGRESS REPORT

Pursuant to Paragraph 104 of the Consent Decree entered on March 11, 1998, the state Defendants agreed to file a semi-annual report with this Court and plaintiffs' counsel

regarding their compliance with the terms of this order. Such reports are to be filed on July 31st and January 31st of each year. Said reports "shall contain information, validated by the applicable audit and testing procedures outlined herein, which accurately and fully reflect the status of the State's compliance with each of the applicable requirements of this order..."

Attached to this notice is a copy of the Semi-Annual Progress Report for the period ending January 31, 2001. This Report contains the following components:

1. Overview of activities during report period
2. Attachment A: EPSDT Project Plan
3. Attachment B: EPSDT Quarterly Reporting Tool and the EPSDT Audit Tool
4. Attachment C: EPSDT Handbook (Draft)
5. Attachment D: Interagency Agreement
6. Attachment E: TSOP on Interperiodic Screenings (Draft)
7. Attachment F: DCS EPSDT Report
8. Attachment G: Proposed Survey Questions for the BHO Consumer Satisfaction Survey
9. Attachment H: Revised Remedial Plan

Pursuant to paragraph 104 of the Consent Decree, this semi-annual report is being provided to plaintiffs' local counsel.

Semi-annual Progress Report

EPSDT Consent Decree January 2001

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Attachment B: EPSDT Quarterly Reporting Tool and the EPSDT Audit Tool

Attachment C: EPSDT Handbook

Attachment D: Interagency Agreement

Attachment E: TSOP on Interperiodic Screenings (Draft)

Attachment F: DCS EPSDT Report

Attachment G: Proposed Survey Questions for the BHO Consumer Satisfaction Survey

Attachment H. Revised Remedial Plan

Overview

Efforts to ensure compliance with the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) Consent Decree as well as to increase public awareness of EPSDT services are ongoing. The Bureau of TennCare and the Department of Children's Services (DCS) are committed to improving the delivery of EPSDT services to their consumers. An overview of the State's progress for the period of August 31, 2000, through January 31, 2001, is contained in this semi-annual progress report.

During the past six months several activities occurred that were not specifically required by the EPSDT Consent Decree but nevertheless will have an impact on the issues identified in the Consent Decree. These activities include the following:

1. **EPSDT Project Plan** The Bureau of TennCare has taken several steps over the last few months in an effort to improve compliance with the EPSDT Consent Decree. In October 2000, Mark E. Reynolds, Deputy Commissioner, Bureau of TennCare, established an EPSDT Steering Committee to give further attention to the Bureau of TennCare's activities related to EPSDT and to closely monitor the progress of compliance. The EPSDT Steering Committee is composed of persons throughout the Bureau who have a role in the implementation of the Consent Decree. The EPSDT Project Plan (See **Attachment A.**) identifies activities and additional steps that will be taken to further ensure compliance with the Consent Decree. The Plan is divided into five major areas: 1. *Improved coordination within TennCare* 2. *Improved outreach to members and informing about EPSDT* 3. *Improved screening rates* 4. *Improved quality of care and 5. Improved interagency coordination.* Commissioner Reynolds regularly attends and facilitates the Steering Committee meetings.

Several activities are outlined in the EPSDT Project Plan and the following is a highlight and progress to date of some of the activities.

A. Improved coordination within TennCare

- An EPSDT Steering Committee of persons throughout the Bureau who have a role in the implementation of *John B.* has been organized and the group has been meeting bi-weekly since October. The role of the Committee is to monitor the Bureau's compliance with *John B.*

- Dr. Joe McGlaughlin has been hired to coordinate children's health services provided through state agencies and departments, including TennCare, the Department of Health, the Department of Children's Services, the Department of Human Services and the Department of Mental Health and Developmental Disabilities. The primary goals will be increasing early and periodic health screenings for all Tennessee children, improving behavioral services for children, and reducing tobacco use among youth.

- On November 30, 2000, a meeting of the EPSDT Coordinators from each managed care organization (MCO) and behavioral health organization (BHO) was organized to inform the Coordinators of the Bureau's increased efforts to improve compliance with the Consent Decree. These meetings will continue to occur on a quarterly basis; and during the meetings, the Coordinators will provide regular updates of the MCO's/BHO's activities regarding compliance with the Decree. The meetings will also serve as a platform to invite other state agencies, for which coordination is appropriate, to the meetings to discuss and identify ways to increase coordination among the MCOs/BHOs and these agencies. The next quarterly meeting is scheduled for February 22, 2001.

B. Improved outreach to members and informing about EPSDT

- TennCare is working to finalize an agreement with the Academy for Educational Development (AED) to conduct focus group research among enrollee families to determine what factors are influential in their decision to take their children for screenings. AED is a national organization involved in conducting qualitative research and developing social marketing strategies for federal, state and local governments, and other agencies focusing on domestic health issues.

- A number of training activities have occurred over the past few months to educate other agencies who work with children and families about the EPSDT program and to encourage their assistance in making families aware of the benefits of preventive health. TennCare has also provided training and assistance to the Division of Mental Retardation Services staff on techniques for accessing TennCare services for children on the waiting list for the statewide Home and Community Based Services Waiver Program.

C. Improved screening rates

- The Bureau has made plans to develop a pilot project with Blue Cross to determine if paying increased fees to providers who can document that they have screened for all seven (7) components of the screening will result in better screening percentages. The first phase of the project is scheduled to begin February 15, 2001, through March 31, 2001. The first phase will consist of developing and testing the administrative processes involved in filing claims with copies of completed EPSDT encounter forms with a small number of providers. The second phase, scheduled to begin in April, will involve a larger number of providers.

D. Improved quality of care

- The Quality Oversight staff is working with the External Quality Review Organization (EQRO) to ensure that the instrument used to conduct the Annual Surveys contains the necessary performance measures/elements to meet compliance with the EPSDT and Grier Consent Decrees. The Office of General Counsel has

provided training to the EQRO leadership staff on both the EPSDT and Grier Consent Decrees.

- In October, the Quality Oversight Division began conducting on-site medical record reviews at physician practices across the state, with an emphasis on educating these practices about EPSDT. An initial pilot study of EPSDT medical record reviews was conducted and a total of 30 records were reviewed for the pilot studies to pre-test the audit tool.

- EPSDT medical record reviews were conducted during October-December 2000 at fifteen provider sites across the State. Enrollees selected for the medical record review were randomly chosen from those receiving a well child preventive visit during the year 2000. A summary of audit findings identifying areas of deficiencies found at these provider sites was prepared. In January, corrective action plans were requested from the managed care organizations for deficiencies found in any of the seven required screening components identified during the medical record reviews. The plans of correction outlining the actions that will be implemented to improve compliance are to be submitted to the Bureau in February. Plans of correction will be requested from MCOs for sites not achieving an 80% compliance rate.

  The Quality Oversight Division has also requested that each managed care organization provide a quarterly report of EPSDT activities. The first quarterly report is due this month. **Attachment B** contains a copy of the quarterly reporting format that will be used and a copy of the audit tool that is used when conducting medical record reviews.

E. Improved interagency coordination

- EPSDT handbooks that were prepared for other state agencies on how to access TennCare and EPSDT services have recently been updated. A draft of the handbook is in **Attachment C**.

2. **Early Child Health Outreach (ECHO)** The Bureau of TennCare is collaborating with the ECHO project to assist in producing additional training materials for them. TennCare is planning to print approximately 20,0000 training packets for the project to use during their training events. The Tennessee Health Care Campaign (THCC) received a three-year grant in November 1999 from the Nathan Cummings Foundation to begin a new program called ECHO. The ECHO program is focused on outreach and education to parents of TennCare-eligible children from birth to six years old. ECHO educates parents about their rights to EPSDT services and their right to file a medical appeal if services are denied, delayed, or terminated by the managed care organization (MCO) or the behavioral health organization (BHO). The THCC is subcontracting with six other organizations to perform media activities, training seminars, and outreach activities including special outreach efforts for Hispanic families. A twelve minute instructional video has been completed that provides information on how to enroll in TennCare, EPSDT services, grievance and appeal rights and important numbers to call when

assistance is needed in accessing EPSDT services. There are English and Spanish versions of the videotape and it can be ordered from the THCC.

3. **TennCare Shelter Enrollment Project** Effective July 2000, the Bureau of TennCare finalized a grant awarded to the NHCHC so that direct training and technical support activities to facilitate TennCare enrollment of homeless children would continue for the 2000-2001 fiscal year. The National Health Care for the Homeless Council (NHCHC) administers the TennCare Shelter Enrollment Project. This program is currently the only source of direct training and technical support available in the state to facilitate TennCare enrollment of homeless children. For the 1999-2000 fiscal year, the Shelter Project expanded its TennCare enrollment and outreach training to focus on strategies that educate and inform homeless parents about the availability of EPSDT services as well as how to access these services for their children. To accomplish this task, the project coordinator plans and organizes regional EPSDT outreach and enrollment workshops in the three grand divisions of the state.

4. **Interagency Agreement** An interagency agreement between the Departments of Education (DOE), Mental Health and Developmental Disabilities (MHDD), Children's Services (DCS), and Finance and Administration (TDFA) has been finalized. A final copy of the agreement can be found in **Attachment D**. The agreement facilitates the provision and coordination of services for infants, toddlers, children, youth and adolescents who are eligible under the Individuals with Disabilities Education Act (IDEA). The agreement also formalizes policies, procedures, and fiscal responsibilities for each department and will be very helpful in resolving problems and making sure that each department is aware of services offered by other departments and how to access services for children. In January 2001, representatives of the state agencies above provided training on the Interagency Agreement.

This training was open to the public and all persons who are involved in services under the IDEA were encouraged to attend. This includes students with disabilities, parents of children with disabilities, individuals and organizations involved in the provision of services to persons eligible for services under the IDEA, and other interested parties.

5. **Suicide trends** The Tennessee Justice Center requested information regarding what they suspected was an increase in suicides for TennCare members under the age of 21 with the advent of the TennCare Partners Program. Staff at the Bureau examined the data for possible trends.

With the assistance of the Department of Health (DOH), the Bureau of TennCare examined the trend in suicides for the years 1994 through the most recent year with complete data, 1999. Below are the number of suicides in the age group eligible for EPSDT services (21 and under), by year:

YEAR	1994	1995	1996	1997	1998	1999
# of Suicides	64	65	66	72	68	49

Personnel at the DOH did upon analysis, determine a trend in the cohort born in 1979. This group historically has accounted for a higher suicide rate. The reasons for the trend among this age group are unknown; this could be related to the size of the group (perhaps there was a higher birth rate in 1978).

Given the large population base (well over one million) that this group constitutes (age 21 and below), it appears that the only real change may be the decline in suicides during the year 1999 (from 68 to 49). Personnel from DOH and the Bureau have examined the data and trends for the years 1994-1999 and there does not seem to be a permanent change brought on by the TennCare Partners Program.

Progress made during the Reporting Period

The paragraph numbers identified below correspond to the paragraphs in the EPSDT Consent Degree.

1. **Interperiodic Screening Requirements** *(Paragraph 42)* A TennCare Standard Operating Procedure on interperiodic screening requirements **(See Attachment E)** is currently being finalized.

2. **Network Adequacy** *(Paragraph 43)* Routine monthly updates have been received and processed; and appropriate additions, deletions, and changes have been made to the provider files. As of July 2000, the Provider Networks Section implemented a new method of obtaining monthly provider update information from the MCOs. This new process is intended to prevent the MCOs from repetitious data submissions and help create a more comprehensive, accurate database with a more current listing of all providers, in and out of the MCO Plan.

The Provider Networks Section has started the process of hiring an additional operator position. This would bring the number of full time operators to two. Operator duties include telephone verification of provider data submitted by the MCOs. The provider's office is called directly to verify contract status and information including the ages of patients the provider is willing to serve, whether the provider is accepting new patients, if the provider offers prenatal care, accepts presumptive eligibles, and determining the length of time to obtain an appointment for routine services.

3. **EPSDT Screening Guidelines Committee** *(Paragraph 44)* As a result of the EPSDT Consent Decree, the Bureau of TennCare established an EPSDT Screening Guidelines Committee. The committee was charged with recommending screening guidelines for providers to help insure that children in need of further hearing and vision and/or behavioral and developmental assessments are identified through the periodic screens. Membership of this committee consisted of EPSDT providers, MCO/BHO medical directors, researchers, practitioners, medical educators and vision, hearing, developmental and behavioral specialists. Members were either nominated by their respective professional organizations—the Tennessee Academy of Family Physicians, the Tennessee Pediatric Society, the Tennessee Medical Association, and the Tennessee Nursing Association, or were recommended by the plaintiffs' attorneys.

Statewide training on the EPSDT screening guidelines was provided in August and September of last year. TennCare providers or representatives from their offices were requested to attend training sessions on the screening guidelines recommended by the EPSDT Screening Guidelines Committee.

On January 9, 2001, the Bureau of TennCare hosted a "Train the Trainer" conference on the EPSDT Screening Guidelines for over 60 MCO and BHO personnel. The goal is to

ensure that each managed care organization provides training to their providers in a consistent, uniform manner.

4. **Screening performance standards** *(Paragraph 49)* The adjusted periodic screening percentage (APSP) for FFY 99 is 19.8%. The APSP is calculated by multiplying the screening percentage reported on the HCFA 416 report by the percentage of required components included in EPSDT screens reported in the annual medical record review.

The dental screening percentage (DSP) is calculated by dividing the actual number of dental encounters provided for children aged 3-20 by the expected number of encounters for children in this age group. The DSP for FFY 99 is 28.5%.

The state has not met the target EPSDT screening requirements of 51.9% for the APSP and 38.2% for the DSP as outlined in the Consent Decree; however, TennCare shall be in compliance with the screening obligations under the law if children who have not received screenings have been the subject of outreach efforts reasonably calculated to ensure their participation. Last fall the Quality Oversight Division completed an extensive survey of the MCOs' outreach and informing activities. The External Quality Review Organization (EQRO) continues to monitor MCO activities related to EPSDT services as a part of the annual surveys and the Ouality Oversight Division will continue to conduct medical record reviews and periodically review the outreach and informing activities of each managed care organization.

5. **Screening Procedure and/or diagnosis codes** *(Paragraph 47)* In October, TennCare's Chief Medical Officer provided the managed care organizations with an updated list of procedure and diagnoses codes to be used for documenting EPSDT screens.

6. **Summary of EPSDT screens for children in DCS custody** *(Paragraph 52)* DCS continues to track EPSDT screenings for children in custody. The most recent report issued (**See Attachment F.**) reports data as of October 2000, and indicates that 86% of children in custody have received a screening and 75% have received a dental screening. The percentage of children with EPSDT exams completed within the first 30 days of entering custody was 53%. These numbers excludes those children who are in Youth Development Centers, on runaway status, or in a detention center.

During the 2000 year, the TNKids tracking was implemented throughout DCS. EPSDT data from the former tracking system was converted and loaded into TNKids. As TNKids was implemented, the DCS Policy Planning and Research Division began developing EPSDT reports from TNKids data. As EPSDT tracking mechanisms has been developed, the department is once again beginning to see improvement in the data indicating the numbers of children who have received annual EPSDT medical screenings. For cumulative data as of May 31, 2000, 74% of children in custody had received a medical EPSDT screening. As of September 30, 2000, that percentage increased, with 85% of children in custody receiving their medical screening, and of those, 56% receiving the screening in 30 days. The department continues to make screening and the documentation of the screenings a priority. In addition to tracking, DCS is in the process

of developing EPSDT policies for department wide use. The policy will provide guidance on coordination of provider and case management activities to promote the best outcome for the child.

7. **Compliance with HCFA access standards** *(Paragraph 61ii)* Quarterly, the Provider Networks Division performs a GeoAccess mapping analyses of the MCOs' inpatient, primary care, dental and prenatal provider networks as well as the BHOs' outpatient, inpatient, and 24-hour residential mental health provider networks. GeoAccess mapping analyses of the BHOs outpatient, inpatient and 24-hour residential mental health provider networks were also performed. Currently, no MCO has a withhold in place for provider network deficiencies. However, each MCO has some provider enrollment file reporting errors. Data elements on the provider enrollment file have been identified as being reported incorrectly. Provider Networks and Information Systems staff are currently working with each of the MCOs to get these data elements corrected.

8. **Coordination of behavioral health services** *(Paragraph 71i)* In order to involve parents and family members, to the greatest extent possible in the determination of behavioral health services to be delivered to children, survey items related to coordination of care have been proposed for inclusion in the BHO Consumer Satisfaction Survey. The proposed survey items have been submitted to the Tennessee Justice Center and are currently under review by advocacy groups. A draft of the proposed survey questions is in **Attachment G**.

9. **Comprehensive scope of geographically accessible child and adolescent behavioral health services** *(Paragraph 71ii)* Regular quarterly GeoAccess mapping analyses of the BHOs provider networks for outpatient, inpatient and 24-hour residential mental health services are in the process of being completed. No withholds are currently in place for network deficiencies for either BHO.

10. **Enhanced monitoring of discharge planning for psychiatric and chemical dependency facilities** *(Paragraph 71iii)* The Quality Oversight Division continues to monitor the delivery of case management services to members of the priority population (CRG 1, CRG 2, TPG 2) who are discharged each month from an inpatient psychiatric hospitalization or residential treatment facility. This monitoring occurs through monthly reports received from the BHOs regarding the number of patients who have been offered case management and received a case management encounter seven days prior to seven days post discharge from a psychiatric inpatient facility/residential treatment facility (RTF). Quality Oversight staff analyzed May 2000 through October 2000 reports and the analysis is as follows:

Indicator 1. Percent of consumers (CRG 1, CRG 2, TPG 2) who were offered a referral for case management.

PREMIER		TBH	
May 2000	98.06%	May 2000	98.25%
June 2000	97.75%	June 2000	99.04%
July 2000	98.25%	July 2000	97.10%
August 2000	98.27%	August 2000	98.22%
September 2000	99.07%	September 2000	98.24%
October 2000	98.52%	October 2000	99.20%

Indicator 2. Percent of consumers who accepted the offer of a referral for case management and received a face to face encounter seven days prior to seven days post discharge.

PREMIER		TBH	
May 2000	87.48%	May 2000	89.46%
June 2000	87.01%	June 2000	87.76%
July 2000	89.42%	July 2000	90.64%
August 2000	89.65%	August 2000	87.07%
September 2000	87.96%	September 2000	86.55%
October 2000	87.22%	October 2000	86.71%

The Quality Oversight Division continues to confer each month with Premier and TBH, as needed, to discuss the analyses and findings of each month's Case Management Report.

A separate analysis is performed on the monthly Case Management Report utilizing the subset of consumers under the age of twenty-one. The Bureau uses the information to evaluate case management provided to this specific group of consumers to identify areas of concern that may require follow-up. In August 2000, Quality Oversight's analysis of the subset revealed that two facilities had fallen below 80% in May and June 2000. It should be noted that all the consumers at these facilities were under the age of twenty-one when discharged. A plan of correction was requested from the BHOs.

In November 2000, the subset report for the period July through September 2000 reflected a significant improvement.

During Quality Oversight's 2000 third quarter analysis of the Community Mental Health Agencies (CMHAs) Summary of Compliance with Case Management, the results identified three CMHAs that fell below an average of 80% compliance rate. A Plan of Correction was requested from the BHOs to identify interventions that would assure TennCare consumers receive a case management encounter within the established guidelines of seven days prior to seven days post discharge from an inpatient/residential treatment setting. Corrective action plans were received and approved.

Two discharge-planning audits have been completed since July 2000. A representative from the BHOs participated in each audit. The discharge-planning audits are conducted in an effort to assess if appropriate discharge planning occurs and that there is continuity of care from the inpatient setting to the outpatient setting for all TennCare consumers. Plans of Correction are requested from the BHOs when the audit findings reveal deficiencies.

Quality Oversight received five initial corrective action plans submitted in response to previous discharge audits. The Division staff reviewed the Plans of Correction and sent letters to the BHOs accepting the corrective actions outlined.

The BHO continues to provide updates on the implementation of the corrective action plans. The implementation of these plans should improve the coordination, collaboration, and continuity of case for TennCare consumers.

11. **Monitoring of a sample of DCS children for service adequacy** *(Paragraph 73)* The Bureau of TennCare is developing a contract for a study of TennCare-eligible who enter state custody to determine the impact and level of services they received prior to custody. This study will be conducted by the Children's Mental Health Services Research center at the University of Tennessee.

This study is in accordance with Paragraph 73 of the consent decree. A previous study was conducted to fulfill this requirement of the consent decree. However, TennCare was concerned about the methodological issues in the study, and we want to commission a new study that will answer our research questions adequately.

The new study will:

- Control for length and consistency of eligibility for TennCare;
- Track a cohort of children who become known to the court prior to actual custody; and
- Identify factors that contribute to a child being placed in state custody (will also look at what may have prevent custody in some cases). This will be obtained by reviewing behavioral health records; interviewing families and assessing children and families; and obtaining data from juvenile court personnel since they perform a critical role at the juncture where state custody is determined.

The Bureau of TennCare is initiating this study as the current director, as have others, expressed a strong commitment to identify what factors, if any, related to TennCare services lead to "children being forced into state custody" and to prevent this, if it does occur. The Tennessee Justice Center has agreed to meet with the research team from the University of Tennessee as they develop their research proposal.

12. **Remedial Plan for Children in the Department of Children's Services' Custody** *(Paragraphs 88-92)* Pursuant to the EPSDT Consent Decree the State and the plaintiffs'

attorneys negotiated a mutually acceptable remedial plan for assuring adequate medical and behavioral services for children in DCS custody. Consultant, Paul DeMuro, facilitated the process and Health Commissioner, Dr. Fredia Wadley, spearheaded the plan. On December 11, 1998, the State filed a proposed plan as required by the Consent Decree. Thereafter, the parties attempted to develop jointly a plan to be filed with the Court for approval. Negotiations broke down and the State filed another proposed plan on February 15, 2000, which superceded the earlier plan. During the following months, the State and the plaintiffs' attorneys were able to resolve their remaining differences and had agreed to the terms of the Plan, which was filed on May 11, 2000, and was signed and approved by Judge John Nixon of the United States District Court on May 16, 2000. This plan superceded the previous plan submitted to the Court on February 15, 2000. The plan called for the development of a Best Practice Network of providers composed of primary care physicians, behavioral health providers, dentists, and children's Centers of Excellence (tertiary pediatric centers).

As efforts to implement the Remedial Plan progressed, members of the health care community voiced concerns about certain provisions contained in the Remedial Plan. In particular, potential providers and Centers of Excellence refused to contract with all of the participating managed care organizations, as required by the Plan. Other providers refused to participate because developing a unique care system designed to accommodate a population that represents less than 1% of the entire TennCare population did not justify the administrative burdens associated with contracting with at least ten managed care companies, each with their own set of administrative procedures for approving, processing and paying claims. The remaining providers were concerned about the potential of being overwhelmed with an influx of children with complex health needs.

As a result of the concerns expressed by the medical community, a modified version of the Remedial Plan has been proposed. Under the revised Remedial Plan (See **Attachment H**), the state would contract with one MCO and one BHO to provide statewide services for children in custody and a certain group of children deemed at "prolonged risk" of custody. The contracts for these entities would represent a management model and put the state at financial risk for services. The plaintiff's attorneys are opposed to the revised plan. The parties anticipate that a hearing on the issue of the revised plan will be held June 2001.

13. **Commissioner's Task Force** *(Paragraph 83)* The Commissioner's Task Force has scheduled a meeting for February 28, 2001. One agenda item for the meeting will be the enhancement of interdepartmental agreements to address EPSDT issues. Dr. Joe McLaughlin will be working on these agreements as part of his new role with the Office of Health Policy.

14. **Tracking system** *(Paragraph 94)* The Bureau of TennCare is working with a consultant to identify a potential vendor of a tracking system that could be added onto our encounter data system.

15. **Review of Appeals** *(Paragraph 101)* This report will be submitted under separate cover.

ATTACHMENT A
EPSDT PROJECT PLAN

EPSDT Project Plan
Bureau of TennCare
Update: January 31, 2001

Area	Activity	Progress/ Timeframe for Completion	Process Measurement
1. Improved coordination within TennCare	1.1 Hire a TennCare EPSDT Coordinator to be responsible for implementation of *John B.*	**Done**	Coordinator hired and on board
	1.2 Organize an EPSDT Steering Committee of persons throughout the Bureau who have a role in the implementation of *John B.* and arrange for biweekly meetings of this group.	**Done**	Meeting notes
	1.3 Conduct quarterly meetings of the EPSDT contact persons from each MCO/BHO.	**Done** for current quarter	Meeting notes
	1.4 Assure that MCOs are providing PCPs with quarterly up-to-date lists of specialists to whom referrals may be made. Share these lists with the Network Adequacy staff. (para. 62)	**Done** for current quarter	Copies of materials sent by each MCO, each quarter
2. Improved outreach to members and informing about EPSDT	2.1 Conduct focus group research among enrollee families to determine what factors are influential in their decision to take their children for screenings. Develop an action plan to follow up on the findings of the research.	Contract being developed with facilitator	Summary of findings from focus groups; action plan
	2.2 Contract with DOH to perform EPSDT outreach and screening outside the MCOs	Discussions underway	Completed contract, along with plan for monitoring contract
	2.3 Develop and implement a public awareness campaign.	Planning underway	Number of public awareness materials developed and distributed
	2.4 Provide EPSDT training to outreach workers with the community health centers who work with homeless families.	**Done** for current quarter	Number of training sessions completed
	2.5 Conduct EPSDT training for emergency shelter and domestic violence staff.	**Done** for current quarter	Number of training sessions completed
	2.6 Coordinate outreach within the ECHO project to include distribution of materials to health departments, DHS, and other agencies.	**Done** for current quarter	Number of outreach activities conducted
	2.7 Send material about EPSDT to the BHOs for inclusion in their newsletters.	**Done**	Copies of BHO newsletters with material inserted

Area	Activity	Progress/ Timeframe for Completion	Process Measurement
3. Improved screening rates	3.1 Finish medical record reviews for 1999. (para. 46)	In progress	Completed annual medical record reviews
	3.2 Develop a pilot project with Blue Cross to determine if paying increased fees to providers who can document that they have screened for all 7 components will result in better screening percentages.	Planning nearly complete	Data from pilot project
	3.3 Conduct focus group research among PCPs to determine their perceptions of the best ways to assure that all required components are documented in screens and develop an action plan to follow up on the research. Secure the services of a facilitator for this project.	Planning underway	Recommendations from focus group; action plan
	3.4 Finalize TSOP on interperiodic screenings. (para. 42)	TSOP drafted and being reviewed by MCOs/BHOs	TSOP distributed
	3.5 See Activity 2.3 above.		
4. Improved quality of care	4.1 Review EQRO monitoring tools to be sure to assure that monitoring of MCOs/BHOs includes: outreach activities (para. 41), provider networks (para. 43), referral provisions (para. 53), use of medical necessity criteria (paras. 55-56), utilization review procedures (para. 58), compliance with access standards (para. 61), availability of behavioral services to children not identified as SED (para. 71iv), non-emergency transportation (paras. 74-77)	Incorporated into new EQRO contract	Monitoring plans, corrective action plans requested, corrective action plans approved, corrective action plans followed up on
	4.2 Summarize content of MCO corrective action plans with respect to improvement in screening percentages.	**Done** for current quarter	Copies of summaries
	4.3 Send MCOs the new list of CPT and ICD codes for use in capturing EPSDT screens. (This list has been supplied to OCDC for the next contract amendment.)	**Done**	Copies of correspondence sent
	4.4 Using a specially developed audit tool, conduct on-site medical record audits at physician practices across the state, with an emphasis on educating these practices about EPSDT.	**Done**	Report of findings

Area	Activity	Progress/ Timeframe for Completion	Process Measurement
	4.5 Begin analyzing EPSDT appeals on a monthly basis, in addition to the semiannual basis required in the Consent Decree (para. 101) and report patterns observed promptly to the offices of QO and CDCU for action. Incorporate access to care issues identified by medical directors.	In process	Monthly analyses; monthly referrals to QO and CDCU; monthly report of action by QO and CDCU
	4.6 Continue to provide training and encouragement for use of the screening tools recommended by the EPSDT Screening Guidelines Committee. Purchase "starter kits" of these tools for providers willing to use them and document all screening components.	Second training event completed	Training plan developed and implemented; Screening tools purchased and distributed
	4.7 Contract with the University of Tennessee to do a study analyzing the relationships between services children receive from MCOs/BHOs and those children's subsequent entrance into or avoidance of custody.	Contract discussions underway	Completed study
	4.8 Insure that a comprehensive and appropriate scope of geographically accessible child and adolescent behavioral health services and a range of treatment settings are provided. (para. 71ii)	**Done** for current quarter	Network reviews completed
	4.9 Insure that appropriate continuity of care and services following psychiatric or chemical dependency inpatient facility services or residential treatment is provided as specific in discharge plans. (para. 71iii)	In process	Review of discharges from psychiatric facilities and chemical dependency units
	4.10 Convene an internal workgroup to develop recommendations for a new tracking system, as well as compiling data on all pertinent provider encounters which involve children and which are covered by TennCare. (paras. 94 and 97) *[Examine web-based possibilities.]*	Plans for a new tracking process are being developed	Completed recommendations
5. Improved interagency coordination	5.1 Update EPSDT handbooks that have already been prepared for other state agencies and provide training to these agencies on how to access EPSDT services.	**Done**	Copies of completed handbooks distributed

Area	Activity	Progress/ Timeframe for Completion	Process Measurement
	5.2 Update interdepartmental agreements between TennCare and DCS, TennCare and MHDD, and TennCare and the Department of Health to reflect roles and responsibilities for EPSDT. These agreements should complement the existing interdepartmental agreement among all of these agencies and the Department of Education. (para. 78)	In process	Copies of completed agreements
	5.3 Update TennCare website with EPSDT guidelines or develop new EPSDT website.	**Done**	Website additions
	5.4 Provide training and assistance to MR staff on EPSDT and on techniques for accessing TennCare services for children on the waiting list.	**Done**	Training events held
	5.5 Update list of services available through state agencies for which EPSDT coordination is appropriate, and distribute to MCOs/BHOs. (para. 79)	**Done**	Completed manuals reissued
	5.6 Notify LEAs again of the process to obtain services from MCOs/BHOs when children have been identified as needing medically related services in a school setting. (para. 81)	**Done**	Copies of correspondence sent
	5.7 Conduct quarterly meetings of the Commissioner's EPSDT Task Force. (para. 83)	Next meeting scheduled for February 28	Meeting notes
6. Other	6.1 Develop and implement a measure for determining if parents and family members are involved to the greatest extent possible in the determination of behavioral services for children. (para. 71i)	**Done**	Process measure developed and plan for implementation completed
	6.2 Conduct quarterly meetings with the plaintiffs' attorneys. (para. 106)	**Done**	Meeting notes
	6.3 Provide monthly updates on progress to attorneys, as well as the required semiannual reports. (para. 104)	In process	Reports

ATTACHMENT B
EPSDT QUARTERLY REPORTING TOOL AND THE EPSDT AUDIT TOOL

TENNCARE EPSDT QUARTERLY REPORT

MCO_____ REPORTING PERIOD_____

Name and Title of Person Completing Report_____

QUARTERLY ENROLLEE DEMOGRAPHICS

_____Number of enrollees <21 years of age.
_____Number of enrollees <21 years of age having special needs.*
_____Number of enrollees <21 years of age case managed.
_____Number of newly eligible enrollees during the quarter <21 years of age.

*Identified as congenital conditions, developmental delays, catastrophic or long term illnesses, etc.

Number of individuals informed of availability of EPSDT Services during the quarter.

_____Parent/Guardian of newly eligible child.
_____TennCare eligible pregnant women.
_____Families in WIC program.
_____Institutional Administrators.
_____Other_____

OUTREACH SERVICES

Methods of informing enrollees of EPSDT services during the quarter. (Please place check mark.)

A. PROCESSES

_____Outreach Representative
_____Public Service Announcements
_____Community Awareness Program
_____Member Services Representative
_____Telephone
_____Face to Face
_____New Member Letter
_____Member Newsletter
_____Posters, Flyers, Brochures
_____Member Handbook Annually
_____Other_____

B. MEMBERS & PROVIDERS

Activities utilized to inform **members/providers** of availability of EPSDT services this quarter.

_____Reminder Cards
_____Brochures
_____Posters
_____Newsletters
_____New Member Letters
_____Provider Newsletter
_____# Provider/EPSDT Rep Visits to Provider
_____Letters
_____Telephone
_____Provider Manual
_____Other_____

Number of new member information regarding EPSDT sent within time frame.

_____Less than 15 days
_____15 to 30 days
_____30 to 45 days
_____45 to 60 days
_____>60 days

_____Number of new member letters returned undelivered during the quarter.

What actions are taken to address returned mail?

_____Contact enrollee by telephone.
_____Remailing
_____Other_____

_____How many enrollees contacted this quarter declined EPSDT services?

What procedures have you used this quarter for contacting members who are:

Blind _____

Illiterate _____

Deaf _____

Non-English Speaking _____

What process is in place to monitor the effectiveness of the procedures for contacting members who are blind, illiterate, deaf or non-English speaking?

_____

COORDINATION WITH OTHER AGENCIES

Coordinated EPSDT services with the following programs during the quarter. (Please use check mark and attach narrative description.)

_____Head Start
_____Educational Systems
_____WIC
_____AFDC
_____Day Care Licensing Agency
_____Health Department
_____Other_____

INTERNAL TRACKING SYSTEM

_____Number of members determined to be past due for EPSDT services during the quarter.
_____Number of records reviewed for compliance with EPSDT standards.

SCREENING SERVICES

_____Number of well-child screenings during the quarter.
_____Number of vision screenings during the quarter.
_____Number of hearing screenings during the quarter.
_____Number of dental screenings during the quarter.

PAST DUE SERVICES AND COMPLIANCE RATES

How are enrollees informed who have not had specific EPSDT services, including the following:

Well-Child Visits:
_____Reminder letter/card _____Telephone _____Other_____

Adolescent Well-Visits:
_____Reminder letter/card _____Telephone _____Other_____

Childhood Immunizations:
_____Reminder letter/card _____Telephone _____Other_____

Adolescent Immunizations:
_____Reminder letter/card _____Telephone _____Other_____

Dental Check-ups:
_____Reminder letter/card _____Telephone _____Other_____

How are member compliance rates monitored for preventive screenings and immunizations?

_____Provider Reports
_____MCO Reports
_____Other_____

Is there a mechanism in place to assure that non-emergency transportation is provided to enrollees?

_____Yes
_____No

BUREAU OF TENNCARE
DIVISION OF QUALITY OVERSIGHT
EPSDT AUDIT TOOL 0-20 YEARS OLD

Name_____ **ID#**_____

Age_____ **D.O.B.** _____ **MCO**_____

Provider_____ **DOS**_____

Reviewer: _____ **DOS NOT DOCUMENTED** ☐

WIC VISIT ONLY ☐

I. HISTORY	YES ☐	NO ☐	
Past	YES ☐	NO ☐	
Family	YES ☐	NO ☐	
Interval	YES ☐	NO ☐	NA ☐
Developmental /Behavioral Assessment	YES ☐	NO ☐	
Nutritional Assessment	YES ☐	NO ☐	
Lead Risk Assessment (6 mos. thru 72 mos.)	YES ☐	NO ☐	NA ☐
Cholesterol Risk Assessment (Begins at 2 years)	YES ☐	NO ☐	NA ☐

II. COMPREHENSIVE UNCLOTHED PHYSICAL	YES ☐	NO ☐	
Exam	YES ☐	NO ☐	
Weight	YES ☐	NO ☐	
Height	YES ☐	NO ☐	
Blood Pressure (Begins @ 3 yrs.)	YES ☐	NO ☐	NA ☐
Head Circumference (thru 24 mos.)	YES ☐	NO ☐	NA ☐
Pelvic Exam (If indicated)	YES ☐	NO ☐	NA ☐

III. LABORATORY TEST	YES ☐	NO ☐	
Newborn Panel	YES ☐	NO ☐	NA ☐
Hemoglobin or Hemocrit (9 mos & 11-20 yrs.)	YES ☐	NO ☐	NA ☐
Urinalysis (5 yrs. & 11 - 20 yrs.)	YES ☐	NO ☐	NA ☐
Lead Screen (12 mos. & 24 mos.)	YES ☐	NO ☐	NA ☐
Cholesterol Test (If Indicated)	YES ☐	NO ☐	NA ☐
TB Test (If Indicated)	YES ☐	NO ☐	NA ☐
STD Screening (If Indicated)	YES ☐	NO ☐	NA ☐
Lead Screen Due to High Risk Assessment	YES ☐	NO ☐	NA ☐

IV. HEALTH EDUCATION YES ☐ NO ☐

V. VISION YES ☐ NO ☐

Subjective vision test should be given at all ages except: **objective vision test** should be done at ages 3, 4, 5, 10, 12, 15, and 19.

VI. HEARING YES ☐ NO ☐

Subjective hearing test should be given at all ages except: newborns may have objective or subjective, **objective hearing test** should be done at ages 3, 4, 5, 10, 12, 15 and 18.

ATTACHMENT C
EPSDT HANDBOOK

EPSDT and TennCare: A Guide for Tennessee Early Intervention System Coordinators

DRAFT

Bureau of TennCare
January 2001

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DRAFT

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Introduction

DRAFT

This handbook is intended as a guide to understanding the TennCare program and the resources it offers for children under age 21 eligible for TennCare. The guide has been developed specifically for providers of mental retardation services in order to help them have a better understanding of how the TennCare program works and how they can get appropriate services for their clients through TennCare.

We expect that this handbook will be updated frequently as new questions arise and as policies evolve. If you have questions you would like to see addressed in future editions, please direct those questions to **Kasi Tiller, Assistant Director of Policy & Intergovernmental Relations, Bureau of TennCare, 729 Church Street, Nashville, TN 37247-6501.** You may also reach her by phone at **(615) 741-0217.**

TennCare Overview and History

On New Year's Day 1994, Tennessee made history by withdrawing from the Medicaid Program and implementing an innovative new health care reform plan called TennCare. TennCare required no new taxes and extended health coverage not only to the nearly 800,000 Tennesseans in the Medicaid population, but also to an approximately 400,000 uninsured or uninsurable persons using a system of managed care. Enrollment was open in 1994 to eligible persons in the uninsured, uninsurable, and Medicaid-eligible categories.

On January 1, 1995, TennCare reached 90% of its target enrollment and closed enrollment in the uninsured category. However, on April 1, 1997, enrollment in the uninsured category re-opened to children under the age of 18 who do not have access to health insurance through a parent or guardian. On May 21, 1997, TennCare enrollment became available for eligible dislocated workers. Enrollment remains open to persons and their dependents who have lost access to a COBRA insurance plan and do not have access to other health insurance.

In an effort to expand coverage to more of Tennessee's uninsured children, the Bureau of TennCare opened enrollment on January 1, 1998, to uninsured Tennesseans under the age of nineteen (19) with access to health insurance whose individual family incomes are below 200% of the poverty level. Effective January 1, 1998, uninsured children under age nineteen(19) who meet the TennCare criteria for uninsured are being allowed to enroll in TennCare indefinitely. Enrollment remains open to persons who are Medicaid-eligible or who are uninsurable as determined by an insurance company's denial (for medical reasons) of health insurance to the individual.

In order to implement TennCare, the State of Tennessee was granted approval by the Health Care Financing Administration (HCFA) for a five (5) year demonstration project under Section 1115 of the Social Security Act. State rules were promulgated to assist in administering the statewide program. TennCare replaced the existing Medicaid Program with a program of managed health care. The initial five year demonstration project ended December 31, 1998. HCFA approved a waiver extention for three years beginning January 1, 1999 through December 31, 2001.

TennCare services are offered through managed care organizations (MCOs) and behavioral health organizations (BHOs) under contract with the State. These MCOs, spread out over the twelve regions of Tennessee, are paid a fixed amount per enrollee per month for the MCO services. BHOs are paid a fixed amount for priority participants and a variable rate for all other TennCare enrollees. The MCOs and BHOs negotiate payment rates with individual providers. Enrollees have a choice of MCOs (and their corresponding BHO partner plan) from those available in their geographic area. TennCare services, as determined medically necessary by the MCO, cover inpatient and outpatient hospital care, physician services, prescription drugs, lab and x-ray services, medical supplies, home health care, hospice care, and ambulance transportation. Excluded from TennCare managed care services are long-term care services and Medicare cross-over payments which are continuing as they were under the former Medicaid system.

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Questions and Answers About TennCare

Step One: Getting Children Enrolled

1. ***What is TennCare?***

TennCare is a health insurance program for people who are eligible for Medicaid or who are Uninsurable or are Uninsured. There are certain groups of uninsured people (people losing Medicaid coverage who do not have access to other insurance, children under age 19, and dislocated workers) who may enroll in TennCare. All TennCare enrollees must also meet basic eligibility criteria: must have a verified Social Security number or have applied for one; be a United States citizen or be a lawfully admitted alien for permanent residence; be a resident of Tennessee, and must not be an inmate of a correctional facility. There are other technical eligibility requirements applicable to the appropriate category that a person must meet to be eligible in the uninsured or uninsurable category.

2. ***Can a person be eligible for TennCare and have other insurance?***

People who are eligible for Medicaid can have other insurance and still be TennCare-eligible. People who are eligible as Uninsured by definition have no other insurance. Most people who are enrolled as Uninsurable also have no other insurance, but some Uninsurables are people who have insurance that does not cover pre-existing conditions and or have a limited insurance policy.

If you are providing a service that is covered both by TennCare and by your client's private insurance, the private insurance should be billed first.

3. ***Does it cost anything for a person to have TennCare?***

There are no cost-sharing obligations for people who are eligible for TennCare through the Medicaid category. Many people with developmental disabilities are eligible for Supplemental Security Income (SSI) which is a Medicaid category. Therefore, people on SSI do not have any TennCare cost-sharing responsibilities.

People who are eligible as Uninsured or Uninsurable and whose family incomes are greater than TennCare's 100% of poverty standard must pay premiums to the State for their TennCare. These people also have deductibles and co-payments on all services other than preventive services.

4. ***Are people with disabilities eligible for TennCare?***

Yes, if they meet the criteria for one of the TennCare eligibility categories. Many people with developmental disabilities are eligible for SSI which means that they are automatically eligible for TennCare. Other people who are not eligible for

SSI may be TennCare eligible if they meet the criteria for one of the other Medicaid eligibility categories or they are determined to be Uninsurable. Uninsurables are people who do not have health insurance and who have been turned down by an insurance company due to a medical or health condition.

To apply for SSI: *Contact the Social Security Administration.*

To apply for Medicaid: *Contact the county office of the Department of Human Services.*

To apply for TennCare as an Uninsurable: *Fill out the TennCare application form, get a letter from an insurance company turning the individual down due to a health or medical reason, and send these two items to the TennCare Bureau, P.O. Box 740, Nashville, TN 37202-0740.*

To apply for TennCare as an Uninsured: *Children under age 19 who do not have access to health insurance may apply for TennCare as Uninsured through their local health departments. Individuals who are losing Medicaid eligibility and who do not have access to other health insurance may apply directly to TennCare as Uninsureds if they apply within 30 days of losing their Medicaid eligibility. The TennCare application form should be filled out and sent to the TennCare Bureau, P.O. Box 740, Nashville, TN 37202-0740.*

NOTE: When helping a client fill out a TennCare application, make sure that the application is filled out completely. Applications which arrive at TennCare with missing or incomplete information may be denied.

5. ***How do I know if a particular individual is already on TennCare?***

Providers can call the **TennCare Information Line at 1-800-669-1851 (741-4800 in the Nashville area)**. They need to know the person's correct name, his or her Social Security number, and his or her date of birth in order for the TennCare Information Line staff to be able to positively identify the individual.

6. ***Where can my constituents go to get TennCare applications and information about TennCare?***

TennCare applications are available at local health departments (see attachments). You can also get them by calling the **TennCare Information Line** at **1-800-669-1851 (741-4800 in the Nashville area)**. People with **hearing impairments** can call the **TTY line at 1-800-772-7647 (313-9240 in the Nashville area)**. There is also a **Spanish-speaking information line** at **1-800-254-7568 (227-7568 in the Nashville area)**.

Step Two: Working with MCOs and BHOs

7. ***What are "Managed Care Organizations" and "Behavioral Health Organizations," and how do TennCare enrollees enroll in them?***

Most TennCare services are delivered through two types of **managed care entities:** an **MCO** (Managed Care Organization) for physical health care and a **BHO** (Behavioral Health Organization) for mental health and substance abuse treatment care. Every person in TennCare belongs to ***both*** an MCO and a BHO. There are currently eight MCOs (with three new potential MCOs for 2001) and two BHOs. A list of the addresses and phone numbers of these organizations is included in this handbook (see attachments).

Current MCOs

Access...MedPlus (statewide)
BlueCare (statewide)
John Deere Health Plan (East TN only)
OmniCare Health Plan (Shelby and Davidson Counties only)
Xantus Health Plan (statewide)
Preferred Health Partnership (East TN only)
TLC Family Care Healthplan (Shelby County, NW and SW Regions)
VHP Community Care (Davidson County only)

Potential New MCOs

Better Health Plans, Inc. (West TN Region)
Healthcare Solutions Group of TN, Inc. (East TN Region)
Universal Care Solutions Group (Middle TN Region)

Current BHOs

Tennessee Behavioral Health (statewide)
Premier Behavioral Systems (statewide)

Each MCO is "partnered" with a BHO, which means that people who are enrolled in a particular MCO are **automatically enrolled** in that MCO's "partner" BHO. The following MCOs are "partnered" with **Premier**.

- BlueCare (except in the East TN Community Service Area and Knox County)
- John Deere
- OmniCare
- Xantus
- VHP Community Care

The following MCOs are "partnered" with **Tennessee Behavioral Health**.

- Access...MedPlus
- BlueCare in the East Tennessee CSA and Knox County
- Preferred Health Partnership
- TLC Family Care Healthplan

(The East Tennessee CSA includes the following counties: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union.)

> EXAMPLE 1: Marcus Jones lives in Shelby County and has chosen TLC as his MCO. Mr. Jones' BHO will be TBH, since that is the BHO which is partnered with TLC.

When people initially enroll in TennCare, they choose an MCO from among those which serve the area in which they live. (If they do not choose an MCO, they are assigned to one.) **They are enrolled in the BHO which is partnered with the MCO which they have chosen (see above).** Enrollees have a period of 45 days after enrollment when they can change MCOs if they wish, and thereafter they can change only once a year during the annual **"change period."** During this change period, every TennCare enrollee is sent a ballot with the names of the MCOs available in the area where he or she lives. If the enrollee wishes to change MCOs, he must return the ballot to TennCare with his or her new choice marked. The ballot must be returned within the timeframe indicated.

There are some circumstances in which a person may change MCOs at another time other than the annual "change period." If a person moves outside the community service area covered by their service plan, or if they have gone through the grievance procedure and obtained approval from the TennCare Bureau, they may change their MCO.

When an enrollee moves outside the community service area he/she will be given fifteen (15) days to select a health plan serving the area where he/she has moved. If the enrollee fails to select a new health plan within fifteen (15) days of moving to a new community service area, the Bureau of TennCare will assign him to a health plan. Until an enrollee selects or is assigned to a subsequent health plan and his/her enrollment is deemed complete, his/her medical care will be the responsibility of the original health plan. The enrollee then has a period of 45 calendar to change his/her choice of health plans in the new community service area.

EXAMPLE 2: Marcus Jones (see Example 1) is planning to move from Memphis to Clarksville. Since Mr. Jones' current MCO, which is TLC, only serves residents of West Tennessee, he must choose a new MCO from among those that serve Clarksville: Access...MedPlus, BlueCare, and Xantus. If he wants to remain with TBH as his BHO, he should select Access...MedPlus or BlueCare as his MCO. If he chooses Xantus at his MCO, his BHO will change to Premier.

8. ***How do providers enroll in an MCO or BHO?***

Providers should contact the individual MCOs or BHOs which serve the areas in which they practice. MCOs and BHOs are required by the State to have adequate provider networks meaning **(a)** that they have enough qualified providers to deliver all covered services to their enrollees and **(b)** that these providers are geographically accessible to their enrollee. As long as they have adequate provider networks, MCOs and BHOs are allowed to establish higher standards for providers than was the case in the Medicaid program. They can also enroll provider types (such as psychologists) who were not allowed to enroll as independent providers in the Medicaid program that preceded TennCare. Neither the MCOs nor the BHOs are required to enroll every provider who wishes to participate.

9. ***How does a person decide which MCO to pick?***

Enrollees must choose from among those MCOs which serve the area in which they live **(see Attachment A.)**. A person who lives in Cookeville, for example, cannot choose VHP Community Care, since that MCO is only available to residents of Davidson County.

Many people choose MCOs on the basis of the doctors they usually go to for care. They ask these doctors which MCO(s) they are enrolled in, and they choose an MCO, which includes their doctor.

10. ***How can I find out in which MCO or BHO an enrollee is enrolled?***

TennCare enrollees have member identification cards from both their MCOs and BHOs. These cards provide the name of the MCO/BHO, information about how to reach them, information about what to do in an emergency, etc. You can also find out MCO/BHO affiliations by calling the **TennCare Information Line at 1-800-669-1851 or 741-4800 in the Nashville area**. Please refer to the response to Question 5 for instructions on how to do this.

11. *What services are available through TennCare?*

A list of services that are covered by the TennCare MCOs and BHOs are available in **Attachment B** of this handbook. TennCare also covers long-term care, meaning services in a Nursing Facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). These services are covered outside the MCOs and BHOs. Other services covered by TennCare outside the MCOs and BHOs are Medicare cost sharing and Home and Community Based Waiver Services (HCBS).

Medicare cost-sharing means Medicare premiums, deductibles, and co-payments for certain Medicaid-eligible enrollees who are also Medicare beneficiaries, as well as for some low-income Medicare beneficiaries who are not Medicaid-eligible. As stated earlier, many persons with mental retardation will be eligible for SSI. TennCare pays the Medicare premiums and cost-sharing obligations for these people as well as pays for services covered up to the Medicare deductible.

Home and Community Based Waiver Services are services delivered under HCBS waiver programs which are separate programs from the TennCare Section 1115 Demonstration Waiver Project. Tennessee has three HCBS waiver programs, two for elderly and/or disabled people and one statewide waiver for persons with developmental disabilities. Services covered by the HCBS waiver for persons with developmental disabilities are shown in **Table 3 in Attachment B**. These services are *in addition to* services covered by the TennCare MCOs and BHOs. They are delivered outside the MCOs and BHOs by service providers under contract to the Division of Mental Retardation Services. Where there are similarities between HCBS waiver services and MCO/BHO covered services, Table 2 includes an explanation of which entity is responsible.

12. *How do I go about getting services from TennCare for a child with developmental disabilities?*

All TennCare services except for EPSDT screenings must be **medically necessary**. The TennCare definition of **"medically necessary"** is as follows:

> *Medical assistance services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:*
>
> *a. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, or injury, and*

b. *Appropriate with regard to standards of good medical practice; and*

c. *Not solely for the convenience of an enrollee, physician, or institution, or other provider; and*

d. *The most appropriate supply or level of services, which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for an enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and*

e. *When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Reconciliation Act of 1989.*

Except in the event of emergencies, a basic premise of the TennCare program is to **start with the primary care provider (PCP)**. Every TennCare enrollee has a primary care provider through his or her MCO. Sometimes the PCP's name is on the enrollee's MCO card. If it is not, the enrollee can find out who the PCP is by contacting the MCO at the telephone number shown on the card.

Make an appointment for a check-up with the individual's PCP. That person can then be a source of referral for other services, such as specialists' services. Keep in mind that in order for the MCO or BHO to pay for a service, it must be **"medically necessary."**

EXAMPLE 3: Your program, ABC Developmental Services, requires developmental assessments for all the clients you admit. Betsy Ellis has applied for admission to your program. Betsy's primary care provider is Dr. Brown. Dr. Brown may agree that it would be nice for Betsy to have a developmental assessment, but he can find no medical reason why such an assessment is necessary. *You should not expect that Dr. Brown will order a developmental assessment for Betsy or that the MCO will pay for such an assessment simply because ABC Developmental Services requires it in order to admit Betsy.* A developmental assessment will be paid for by the MCO only when it is medically necessary for Betsy.

13. *What is "prior authorization," and why is it important?*

A number of MCO and BHO services require "prior authorization" in order for them to be paid for by the MCO or BHO. "Prior authorization" means that the provider must call the MCO or BHO and explain why a particular service is medically necessary for a particular enrollee. MCOs and BHOs may agree that

the service is medically necessary; however, they have the discretion to require that a provider in their network deliver the service, unless it is an emergency. If a medical professional prescribes a covered service which the MCO or BHO determines is not medically necessary, the enrollee may appeal the MCO's or BHO's decision. (See response to Question 21.)

14. ***How can I get help for a TennCare enrollee in the event of an emergency?***

In an emergency, you should take the individual to the nearest health care provider, regardless of whether or not that provider is a member of the enrollee's MCO or BHO network. ***You should be aware that the State requires MCOs and BHOs to deliver emergency services without prior authorization and without requiring that a network provider deliver the service.*** MCOs and BHOs usually ask that providers of emergency services let them know about the emergency situation within 24 hours after it has occurred. TennCare's definition of **emergency medical condition** is as follows:

> *a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:*
>
> *(a) Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy;*
>
> *(b) Serious impairment to bodily functions; or*
>
> *(c) Serious dysfunction of any bodily organ or part.*

15. ***Can I get mental health crisis services for a person in my program that is experiencing a psychiatric crisis?***

Yes. You can call a statewide toll-free number **(1-800-809-9957)** which will connect you to the provider of crisis services in your community. The person does not have to be TennCare eligible to receive mental health crisis services.

Step Four: Understanding EPSDT

16. ***What is EPSDT, and how can it help my clients?***

"EPSDT" stands for **Early and Periodic Screening, Diagnosis, and Treatment**. This is a very important program for children under the age of 21.

Every client you have who is TennCare-eligible and who is also under the age of 21 is eligible for EPSDT. These clients should get regular check-ups even if there is no apparent health problem. The MCOs should provide EPSDT screens at the following times.

For infants and toddlers:

At birth	4 months old	15 months old
2-4 days old	6 months old	18 months old
1 month old	9 months old	24 months old
2 months old	12 months old	

For older children and adolescents:

3 years old	11 years old	17 years old
4 years old	12 years old	18 years old
5 years old	13 years old	19 years old
6 years old	14 years old	20 years old
8 years old	15 years old	
10 years old	16 years old	

If our enrollee suspects a problem, he or she should go ahead and arrange for an EPSDT check-up even if it is not yet time for one. This referral is called an "interperiodic screen" and *must* be followed-up by the MCO. EPSDT screens, including "interperiodic screens," do *not* have to be "medically necessary" in order to be covered by the MCO.

> EXAMPLE 4: Mary Anderson, who is 12 years old, had an EPSDT screening six months ago. She is not due to have another one for six months. A staff member in Mary's group home notices on an outing to the park that Mary seems to be having trouble hearing. The staff member should refer Mary to her PCP for an *interperiodic screen* to find out if there is a problem that needs more action. There is no need to wait until the next regularly scheduled *periodic screening*.

The individual in the MCO who does the EPSDT screens is generally the child's primary care provider (PCP). If the child's PCP does not do EPSDT check-ups, contact the EPSDT coordinator at the child's MCO and they will help you find an

EPSDT provider. An EPSDT coordinator serves as a liaison between the public and the MCO/BHO regarding issues pertaining to EPSDT. For instance, the coordinator may assist an individual in scheduling an appointment or helping with transportation needs. Each MCO/BHO has a designated coordinator to assist with EPSDT related issues.

Just as important as the screenings is the follow-up. Providers who perform EPSDT screens may identify potential health, developmental, or behavioral problems. They are responsible for making referrals to other MCO and BHO providers to do further testing or to provide treatment as appropriate. While there is no requirement that EPSDT periodic or interperiodic screenings be medically necessary, additional testing and treatment services must meet the medical necessity criteria outlined in the response to Question 12.

17. ***What about children who are in State custody?***

The Department of Children's Services (DCS) is responsible for children in State custody. A list of services covered by the MCOs, BHOs, and DCS is provided in **Table 3 in Attachment B.**

18. ***What mental health and substance abuse services are available under TennCare for children with disabilities?***

Mental health and substance abuse treatment services are delivered under the TennCare Partners Program. Two BHOs have contracted with the State to deliver these services.

There are two levels of mental health and substance abuse treatment benefits for TennCare enrollees. The basic level of benefits includes psychiatric inpatient facility and physician services, outpatient mental health services, limited alcohol and drug abuse benefits (**see Table 2**), pharmacy and lab services, transportation, and crisis services. The enhanced level of benefits includes mental health case management, residential treatment, psychiatric housing services, unlimited alcohol and drug abuse benefits, specialized outpatient mental health services, and psychiatric rehabilitation services. These services are offered in addition to all the basic benefits.

The basic level of benefits is available to all TennCare enrollees, regardless of whether they happen to have other diagnoses such as mental retardation. The enhanced benefits are available, when medically necessary, for all children under age 21 and for those adults who have been determined to be Severely and/or Persistently Mentally Ill, or "SPMI" and also for children under the age of 18 that are seriously emotionally disturbed or "SED".

You may hear two terms used in discussion of persons with serious mental illnesses and functional impairments. SPMI and SED determinations are made by

Community Mental Health Centers, Regional Mental Health Institutes, and Community Case Management Agencies working under contract to the BHOs. If you have a client with developmental disabilities who you believe is also mentally ill, you can call the nearest CMHA for an appointment to get a SPMI or SED rating. If you do not know where to call or you have trouble making the appointment, call the individual's BHO for assistance.

Based on EPSDT requirements, TennCare enrollees who are either SPMI or SED *and* who are under age 21 are eligible for any benefit covered by TennCare when the service is medically necessary. This means that an individual does not have to be identified as SED or SPMI in order to be eligible for enhanced services which have been determined to be medically necessary for him. For enrollees 21 years of age and older, medically necessary enhanced benefits are available only for persons identified as SPMI.

If you have questions about mental health or substance abuse treatment benefits, you can call the enrollee's BHO or the TennCare Partners Information Line at 1-800-758-1638 (242-7339 in the Nashville area).

19. ***Is there someone who can help a family who is having trouble accessing TennCare services for their child?***

Yes. There is a Consumer Advocacy Line which has been set up by TennCare for the express purpose of assisting individuals with multiple health problems and others who are having difficulty navigating the TennCare system. The number for the Consumer Advocacy Line is **1-800-722-7474 (313-9972 in the Nashville area)**. They will assign a caseworker to help the individual having difficulty or his representatives.

20. ***What transportation services are available through TennCare for my clients?***

TennCare pays for transportation to covered services for those people who do not have an available source of transportation. The MCO pays for transportation to MCO-covered services while the BHO pays for transportation to BHO-covered services. The Member Handbook from the MCOs and BHOs outline the procedures for requesting transportation services or you can call the EPSDT coordinator at the MCO or BHO for assistance relating to EPSDT services.

Step Five: How to File an Appeal

*21. **How do clients file an appeal?***

When a client or a client's representative has a concern about TennCare, the first step should be to talk to the provider and the MCO or BHO. If the situation cannot be resolved at that level, the client may file an *appeal.* MCOs and BHOs have contact persons available to assist enrollees with appeals. You can call them directly or call the TennCare Solutions Unit at 1-800-878-3192 (253-4479 in the Nashville area).

An *appeal* refers to the enrollee's right to protest any action taken by the MCO or BHO which results in a denial, termination, suspension, reduction, or delay of a medically necessary covered service or acts of omission by the MCO or TennCare that impair the quality, timeliness, or availability of such benefits. MCOs and BHOs are required to issue a plain language written notice to the enrollee of any action they are taking to deny, terminate, suspend, reduce, or delay medical assistance. The MCO must respond to the initial request at a maximum of 21 days or earlier if the medical condition is urgent. A written notice shall be given to an enrollee by his/her MCO/BHO of any action taken by the MCO/BHO to deny, reduce, suspend, or terminate medical assistance. A written notice shall be given to an enrollee whenever his or her MCO/BHO has reason to expect that covered medical assistance for the enrollee will be delayed beyond the time lines prescribed by the terms and conditions of the TennCare contract.

Once an enrollee has received a written notice of denial, termination, suspension, reduction, or delay of medically necessary covered services, he or his representative has several options if he disagrees with the proposed course of action. These options are as follows.

a. He may *appeal* the adverse action to the MCO or BHO. The appeal may be expressed by phone, in person or in writing to the TennCare Solutions Unit. The enrollee has 30 days to appeal. Reasonable accommodations will be made for persons with disabilities who require assistance with their appeal. These accommodations could include such things as an appeal in person, by telephone, or by TTY services or other communication device for people with disabilities. The appeal must be resolved in writing within 90 days from the date the appeal is received. *All* of the following events must occur within this 90 day period:

- The MCO or BHO reviews the appeal and makes a decision;
- If the issue is not resolved at the MCO/BHO level, TennCare reviews the appeal and makes a decision;

- If the issue is not resolved by TennCare, a hearing for the enrollee before an impartial hearing officer or administrative judge is arranged; and
- The impartial hearing officer or administrative judge renders a written decision.

b. He may request an *expedited appeal* if the action proposed by the MCO or BHO will result in denying him urgent care. The enrollee or his representative must attest that the enrollee requires urgent care in order for his appeal to be expedited. Expedited appeals must be resolved within 31 days from the date the appeal is filed. *All* of the following events must occur within the 31 day period:

- The MCO or BHO reviews the appeal and makes a decision;
- If the issue is not resolved at the MCO/BHO level, TennCare reviews the appeal and makes a decision;
- If the issue is not resolved by TennCare, a hearing for the enrollee before an impartial hearing officer or administrative judge is arranged; and
- The impartial hearing officer or administrative judge renders a written decision.

If the 90/31 day timeline is not met, the service is to be provided pending the hearing decision if covered, prescribed and not medically contraindicated.

c. If the action proposed by the MCO or BHO will result in terminating, reducing, or suspending ongoing services, the enrollee or his representative may appeal and request *continuation of services* during the appeal process. The request for continuation of services must be made within 10 days of the enrollee's receipt of notice from the MCO or BHO and before the service actually ends. If the decision is in favor of the enrollee the MCO must provide the service within 5 days unless good cause is shown that the service cannot be provided in 5 days.

d. Pharmacists must give a written notice of a denial. The enrollee is entitled to a 14-day supply of their prescription, even if there is a denial. If the prescription is for more than 14 days, the enrollee may file an appeal to get the remainder of the prescription filled by filling in a "drug store form."

Attachment A

TennCare MCOs and BHOs

MANAGED CARE ORGANIZATIONS
For Medical Services Only
Updated 01/30/01

ADMINISTRATIVE OFFICES		PROVIDER SERVICES	MEMBER SERVICES
VOLUNTEER STATE HEALTH PLAN ***(BlueCare: Formerly BlueCross BlueShield of TN)*** 801 Pine Street Chattanooga, Tennessee 37402-2555 ATT: Vicky Gregg, President and CEO (423) 752-6767 FAX: (423) 752-6790 ***Serving:*** ***First Tennessee*** ***Southeast*** ***Upper Cumberland*** ***Mid Cumberland*** ***South Central Tennessee*** ***Northwest Tennessee*** ***Southwest Tennessee*** ***Davidson County*** ***Hamilton Count*** ***Shelby County*** ***Knox County*** ***East Tennessee***	First Tennessee Southeast, Upper Cumberland, and Hamilton County Mid Cumberland, South Central, and Davidson County Northwest, Southwest and Shelby County East Tennessee and Knox County	1-800-468-9736 1-800-468-9786 1-800-818-0962 1-800-468-9772 1-800-468-9751	1-800-468-9698 1-800-468-9775 1-800-205-4983 1-800-468-9770 1-800-468-9771
HERITAGE NATIONAL HEALTH PLAN OF TENNESSEE, INC. ***(John Deere Health Care/Heritage National Health Plan)*** Executive Tower I 408 North Cedar Bluff Road, Suite 400 Knoxville, Tennessee 37923 ATT: Tina Brill, Regional Manager Government Programs (865) 769-1559 FAX: (865) 690-1941 ***Serving:*** ***First Tennessee*** ***Knox County*** ***East Tennessee*** ***Hamilton County*** ***Southeast Tennessee***	First Tennessee East Tennessee, Southeast Tennessee, Hamilton County, and Knox County	(865) 690-5572 (865) 690-5572	1-800-224-6602 1-800-209-0034
MEMPHIS MANAGED CARE CORPORATION ***(TLC Family Care Healthplan)*** P.O. Box 49 Memphis, TN 38101 ATT: Al King, President (901) 725-7100 ext. 3001 FAX: (901) 725-2846 ***Serving:*** ***Shelby County*** ***Northwest*** ***Southwest***	Shelby County Northwest and Southwest	(901) 725-7100 1-800-473-6523 For FED-X purposes: 1407 Union Avenue Suite 1100 Memphis, TN 38104-3627	(901) 725-7100 1-800-473-6523

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ADMINISTRATIVE OFFICES	PROVIDER SERVICES	MEMBER SERVICES
OMNICARE HEALTH PLAN, INC. ***(OmniCare Health Plan)*** 1991 Corporate Avenue, 5th Floor Memphis, Tennessee 38132 ATT: Osbie L. Howard, Executive Director (901) 346-0064 FAX: (901) 348-2212 ***Serving:*** ***Shelby County*** ***Davidson County***	1-800-346-0034	1-800-876-9758
XANTUS CORPORATION ***(Xantus Gold formerly Phoenix Healthcare)*** 3401 West End Avenue, Suite 470 Nashville, Tennessee 37203-1069 ATT: John Gore, Chief of Health Plan (615) 460-0264 FAX: (615) 463-0809 ***Serving:*** ***Statewide***	1-800-242-8840	1-800-449-3339
PREFERRED HEALTH PARTNERSHIP OF TENNESSEE, INC. ***[Preferred Health Partnership (PHP)]*** 1420 Centerpoint Blvd. Knoxville, Tennessee 37932 ATT: Peggy McCurry, Director (865) 470-7470 FAX: (865) 470-7404 ***Serving:*** ***First Tennessee*** ***East Tennessee*** ***Southeast Tennessee*** ***Hamilton County*** ***Knox County***	1-800-747-0008	1-800-747-0008
TENNESSEE MANAGED CARE NETWORK ***(Access...MedPLUS)*** 210 Athens Way Nashville, Tennessee 37228 ATT: Glen Watson, Chief Executive Officer (615) 313-3948 FAX: (615) 313-2344; (615) 687-4035 {205 Reidhurst - (615) 329-2016 FAX: (615) 313-2392} ***Serving:*** ***Statewide***	1-800-494-8068	1-800-523-3112
VUMC CARE, INC. ***(VHP Community Care)*** 215 Centerview Drive, Suite 300 Brentwood, Tennessee 37027 ATT: Philip Hertik, Chief Executive Officer (615) 782-7879 FAX: (615) 782-7812 ***Serving:*** ***Davidson County***	(615) 782-7878	(615) 782-7878

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POTENTIAL NEW MCO's FOR 2001

UNIVERSAL CARE OF TENNESSEE
1600 East Hill Street
Signal Hill, California 90806
ATT: Jay B. Davis, President
(562) 981-4096 FAX: (562) 981-4028

BETTER HEALTH PLANS INC.
C/o Three River Administrative Services, LLC
300 Oxford Drive
Monroeville, Pennsylvania 15146-2356
ATT: Francine Carbo, Administrative Assistant
(412) 858-4000 FAX: (412) 856-1475

HEALTHCARE SOLUTIONS GROUP OF TENNESSEE, INC.
880 South Gay Street Suite 1600
Knoxville, Tennessee 37929
ATT: Kerry McDonald, CEO
(865) 637-2441 FAX: (865) 582-3000

BEHAVIORAL HEALTH ORGANIZATIONS

For Mental Health/Substance Abuse Services Only

Updated 1-30-01

ADMINISTRATIVE OFFICES	PROVIDER SERVICES	MEMBER SERVICES
Premier Behavioral Systems of Tennessee 222 Second Avenue North, Suite 220 Nashville, Tennessee 37201 ATT: Charles D. Klusener, Chief Manager (615) 313-4549 FAX: (615) 743-2131 **Serving: Statewide**	1-800-325-7864	1-800-325-7864
Tennessee Behavioral Health, Inc. 222 Second Avenue North, Suite 220 Nashville, Tennessee 37201 ATT: Charles D. Klusener, President (615) 313-4549 FAX: (615) 743-2131 **Serving: Statewide**	1-800-447-7242	1-800-447-7242

Attachment B

TennCare Covered Services

Table 1 – MCO Covered Services
Table 2 – BHO Covered Services
Table 3 – Home & Community Based Waiver Services for Persons with Developmental Disabilities
Table 4 – EPSDT Covered Benefits

TABLE 1

MCO COVERED SERVICE	BENEFIT
Inpatient Hospital Days (including days at a designated perinatal center)	As medically necessary. Preadmission approval and concurrent reviews allowed.
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Physician Outpatient Services	As medically necessary. This shall include acupuncture performed by a Physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Lab & X-Ray Services	As medically necessary.
Newborn Services	As medically necessary including circumcisions performed by a physician.
Hospice Care (must be provided by an organization certified pursuant to Medicare Hospice requirements)	As medically necessary.
Dental Services	Preventive, diagnostic and treatment services for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance.) Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth).

Vision Services	Preventive, diagnostic and treatment services (including eyeglasses) for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.
Home Health Care	As medically necessary.
Pharmacy	As medically necessary. Non-covered therapeutic classes as described in Section 2-3.t., DESI, LTE, IRS drugs excluded.
Durable Medical Equipment	As medically necessary.
Medical Supplies	As medically necessary.
Emergency Ambulance Transportation	As medically necessary.
Non-Emergency Ambulance Transportation	As medically necessary.
Non-Emergency Transportation	As necessary for enrollees lacking accessible transportation for covered services. The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services, as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment.
Community Health Services	As medically necessary.
Renal Dialysis Services	As medically necessary.
EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act	Screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act

of 1989.		of 1989 for enrollees under 21. Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment XIV of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.
Rehabilitation Services		As medically necessary when determined cost effective by the MCO. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
Chiropractic Services		When determined cost effective by the MCO.
Private Duty Nursing		As medically necessary and when prescribed by an attending physician for treatment and services rendered by registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy		As medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
Sitter		As medically necessary, a sitter who is not a

	relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.
Convalescent Care	Upon receipt of proof that a Covered Person has incurred Medically Necessary expenses related to convalescent care, the Plan shall pay for up to and including the one-hundredth (100th) day of confinement during any calendar year for convalescent facility(ies) room, board and general nursing care, provided: (1.) a Physician recommends confinement for convalescence; (2.) the enrollee is under the continuous care of a Physician during the entire period of confinement; and (3) the confinement is required for other than custodial care.
Donor Organ Procurement	As medically necessary for a covered organ transplant.
Existing covered benefits that have been added to this Section as the result of consolidation of the previous Attachment IX into this Section.	
Reconstructive Breast Surgery	In accordance with Tennessee Public Chapter 452 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. Note: TENNCARE shall develop a procedure code listing of applicable codes which will be provided in subsequent revisions.

Table 2

Mental Health and Substance Abuse Benefits Under the TennnCare Partners Program

Mental Health and Substance Abuse Benefits	Basic Benefit Package (all benefits must be medically necessary)	Enhanced Benefit Package (for those in the Priority Population) ⇒
Psychiatric Inpatient Facility Services		
Under 21	As medically necessary	As medically necessary
Age 21-65	Limited to 30 days per occasion, 60 days per year per enrollee❶	As medically necessary
Over 65	As medically necessary	As medically necessary
Physician Psychiatric Inpatient Services	As medically necessary	As medically necessary
Outpatient Mental Health Services	As medically necessary.	As medically necessary (no lifetime dollar limit)
Inpatient❸ and Outpatient Substance Abuse Treatment Services	• 10 days detox❷ • Inpatient and outpatient substance abuse benefits have a maximum lifetime limitation of $30,000❹	As medically necessary (no lifetime dollar limit)
Psychiatric Pharmacy Services ⇐⇑and Pharmacy-Related Lab Services	As medically necessary	As medically necessary
Transportation to Covered Mental Health Services	As medically necessary for enrollees lacking accessible transportation The availability of specialty services, as related to travel distance should meet the usual and customary standards for the community. However, in the event the BHO has no contracted provider for specialty services that meets the travel distance or other access requirements, transportation must be provided to an enrollee regardless of whether or not the enrollee has access to transportation. If the enrollee is a child and needs to be accompanied by an adult, transportation must be provided for both the child and the accompanying adult.	As medically necessary for enrollees lacking accessible transportation The availability of specialty services, as related to travel distance should meet the usual and customary standards for the community. However, in the event the BHO has no contracted provider for specialty services that meets the travel distance or other access requirements, transportation must be provided to an enrollee regardless of whether or not the enrollee has access to transportation. If the enrollee is a child and needs to be accompanied by an adult, transportation must be provided for both the child and the accompanying adult.

Mental Health Case Management		Must be offered to all persons with assessments of CRG 1, CRG 2 or TPG 2. As clinically indicated for CRG 3.
24-Hour Residential Treatment		As medically necessary
Housing/Residential Care❹		As medically necessary
Specialized Outpatient and Symptom Management		As medically necessary
Specialized Crisis Services	As medically necessary	As medically necessary
Psychiatric Rehabilitation Services		As medically necessary

❶If medically appropriate for the patient, the BHO may authorize substitution of outpatient days, partial hospitalization days, or residential treatment days for covered psychiatric inpatient facility days. Two substitute days will count as one inpatient day. No substitute day may be counted toward any other benefit limit.

❷In accordance with federal EPSDT requirements, the **Contractor** shall be required to exceed service limits when medically necessary for children under the age of 21.

❸When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services.

❹Housing/Residential Care is a covered service only when medically necessary for an individual's living environment to be supervised, structured and/or assisted by mental health staff.

Mental Health and Substance Abuse Maximum Lifetime Limitations

Basic Benefits Package	**Maximum Lifetime Benefits**
Outpatient Mental Health Services (including physician services)	As medically necessary
Substance Abuse Benefits (Inpatient and Outpatient)	$ 30,000, including a maximum of 10 days detox

Enhanced Benefits Package	**Maximum Lifetime Limitations**
Outpatient Mental Health Services (including physician services)	No lifetime dollar limit
Inpatient and Outpatient Substance Abuse Treatment Services	No lifetime dollar limit
Mental Health Case Management Required service	No lifetime dollar limit
All other enhanced mental health services for **Priority Participants**	As medically necessary No lifetime dollar limit

In accordance with federal EPSDT regulations, these limits shall not apply to children under twenty one (21) years of age. They also shall not apply to adults, 21 years of age or older, who have been identified as belonging in the **Priority Population.**

Mental Health Case Management

The **Contractor** will provide Mental Health Case Management services only through Mental Health Case Management Agencies (MHCMAs) which are licensed by **TDMHMR**.

Judicial Services

The **Contractor** must provide covered court ordered mental health services to **Participants** in the Partners Program and to **Judicials** at the direction of the court in accordance with **TDMHMR** service standards and **TDMHMR** forensic standards.

Table 3

Services Covered by the TennCare Home and Community Based Services Waiver for Persons with Developmental Disabilities

Services Covered by the HCBS Waiver	Relationship to TennCare Covered Services
Support Coordination	Not covered by TennCare
Personal Assistant Services	Not covered by TennCare
Respite Care	Not covered by TennCare
Residential habilitation	Not covered by TennCare
Day habilitation	Not covered by TennCare
Supported Employment	Not covered by TennCare
Environmental accessibility adaptations	Durable medical equipment is provided by the MCO's. "Environmental accessibility adaptations" are necessary modifications of the home (widening doorways to accommodate wheelchairs, installing wheelchair ramps, modification of bathroom facilities), and are covered by the HCBS waiver.
Transportation	The MCO and BHO provide transportation to MCO and BHO covered services. The HCBS waiver provides transportation to waiver services, to community services or other activities specified in the individual's Plan of Care.
Specialized Equipment and supplies and assistive technology	Durable medical equipment (including orthotics and prosthetics) and medical supplies, as well as augmentative communication devices, are the responsibility of the MCO; other items not normally covered by the MCO are covered by the HCBS waiver. Hearing aids and related audiological testing for children under 21 are covered by the MCO; the HCBS waiver covers hearing aids and related audiological testing for adults 21 and older.
Family Education	Not covered by TennCare
Community Participation	Not covered by TennCare
Family–based living	Not covered by TennCare
Supported living	Not covered by TennCare
Behavioral Support	Coverage of specialized behavioral support services is the responsibility of the BHO. The HCBS waiver covers behavioral support services that are defined as the support provided to persons who display challenging behaviors that make it difficult to support them in their home and

Behavioral Support (Continued)	community. These support may be provided on a short or long-term basis and include the following: Person centered planning and facilitation support to determine current and preferred lifestyle as related to behavior challenge; environmental assessment; functional assessment; technically developed behavior analysis; development of behavior intervention strategies (behavior support plan); periodic assessment to analyze progress and establish activities for continued follow through.
Enhanced Dental Services	Enhanced Dental Services are accepted dental procedures provided as specified in the plan of care after any Medicaid State Plan or TennCare dental coverage has been sought and exhausted, including all TennCare benefits for persons under the age of 21, and to only those individuals with dental problems which are sufficient to lead to more generalized disease, infection, discomfort, or improper nutrition, if untreated. The determination of dental problems that might lead to disease, infection, discomfort, or improper nutrition will be made by a dentist. Enhanced dental services may include root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection.
Nursing Services	The MCO is responsible when intermittent skilled nursing visits or private duty nursing are necessary for an enrollee who is homebound. The HCBS waiver is responsible for these services when the enrollee is NOT homebound.
Physical Therapy	The MCO is responsible for medically necessary physical therapy related to acute conditions that have recently occurred. The HCBS waiver is responsible for other types of physical therapy, including routine evaluations and reevaluations, provision of chronic care, and physical therapy for loss or impairment that occurred remotely in time.
Occupational Therapy	The MCO is responsible for medically necessary occupational therapy related to acute conditions that have recently occurred. The HCBS waiver is responsible for other types of occupational therapy, including routine evaluations and reevaluations, provision of chronic care, and occupational therapy related to a condition that occurred remotely in time.
Nutrition Services	The MCO is responsible for covering nutrition services when there is a specific medical illness or condition (e.g., renal disease, diabetes mellitus) those items that are not normally covered by the MCO are covered by the HCBS waiver.
Speech, Hearing and Language services	• The MCO is responsible for coverage of speech therapy when loss or impairment of speech is due to an acute event that has recently occurred. The HCBS waiver is

Speech, Hearing and Language services (continued)	responsible for other types of speech therapy, including routine evaluations and re-evaluations, provision of chronic care, and speech therapy related to a condition that occurred remotely in time. • The MCO is responsible for the treatment of diseases or conditions of the ear requiring medical or surgical intervention. For children under 21, the MCO is also responsible for provision of hearing aids and related audiological testing, as well as routine evaluations and re-evaluations. For adults 21 and older, these services are provided by the HCBS waiver.

Table 4
Scope of Covered Benefits Under EPSDT

Note 1: All services other than EPSDT screenings must be medically necessary.
Note 2: DCS "physical custody" means that DCS provides or arranges for the placement of the individual. Some children may be in DCS legal custody, but not physical custody. These are children who have been placed in DCS custody by the court but who continue to live with parents, relatives, etc. TennCare-eligible children in DCS legal but not physical custody receive the same services from the BHOs that children who are not in custody receive.

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
1	Acute inpatient hospital services	X		
2	Psychiatric inpatient facility services		X	
3	Outpatient hospital services	X		
4	Outpatient mental health services		X	
5	Physician inpatient services	X		
6	Physician psychiatric inpatient services		X	
7	Physician outpatient services	X		
8	Inpatient and outpatient substance abuse treatment		X *(as medically necessary*	X *(for children in DCS*

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
	programs		*except for enrollees who are children in DCS physical custody; for these children, the BHO is responsible for a maximum of 10 days detox and a maximum lifetime limitation of $30,000 on inpatient and outpatient substance abuse treatment benefits)*	*physical custody, detox days in excess of 10 and inpatient and outpatient substance abuse treatment benefits in excess of the maximum lifetime limitation of $30,000)*
9	Lab & x-ray services	X *(except for lab services related to psychotropic or substance abuse drugs)*	X *(lab services related to psychotropic or substance abuse drugs)*	
10	Newborn services	X		
11	Hospice care	X		
12	Dental services	X		
13	Vision services	X		
14	Home health care *For psychiatric home health care, see categories #4 and #32.*	X		
15	Pharmacy	X *(except for drugs related to mental health and substance abuse treatment)*	X* *(for mental health and substance abuse treatment)*	
16	Durable medical equipment	X		

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
17	Medical supplies	X		
18	Emergency ambulance transportation	X *(except for transportation related to mental health and substance abuse treatment)*	X *(for mental health and substance abuse treatment)*	
19	Non-emergency ambulance transportation	X *(except for transportation related to mental health and substance abuse treatment)*	X *(for mental health and substance abuse treatment)*	
20	Non-emergency transportation to covered services	X *(except for transportation related to mental health and substance abuse treatment)*	X *(for mental health and substance abuse treatment)*	
21	Community health services *For Community Mental Health Center services, see categories #4 and #32.*	X		
22	Renal dialysis services	X		
23	EPSDT screenings	X		
24	EPSDT diagnostic and treatment services	X *(except for mental health and substance abuse problems)*	X *(for mental health and substance abuse problems)*	
25	Developmental assessments	X *(unless the child has a*	X *(if the child has a*	

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
		previously diagnosed mental illness)	*previously diagnosed mental illness)*	
26	Rehabilitation services	X *(except for psychiatric rehabilitation services)*	X *(psychiatric rehabilitation services for children not in DCS physical custody)*	X *(psychiatric rehabilitation services for children in DCS physical custody)*
27	Chiropractic services	X *(when determined cost effective by the MCO)*		
28	Private duty nursing *For psychiatric private duty nursing services, see categories #4 and #32.*	X		
29	Speech therapy	X		
30	Case management	X	X *(mental health case management for children not in DCS physical custody)*	X *(targeted case management for children in State custody or at risk of State custody; mental health case management when medically necessary for children in DCS physical custody)*
31	24-hour residential treatment		X *(for children not in DCS physical custody)*	X *(for children in DCS physical custody)*
32	Specialized outpatient and symptom management		X *(for children not in DCS*	X *(for children in DCS*

	Service	MCO Responsibility	BHO Responsibility	DCS Responsibility
	services		*physical custody)*	*physical custody)*
33	Specialized crisis services		X *(for children not in DCS physical custody)*	X *(for children in DCS physical custody)*
34	Children's therapeutic intervention services			X *(for children in DCS physical or legal custody)*
35	Services in an intermediate care facility for the mentally retarded *(covered by TennCare outside the MCOs and BHOs)*			
36	Services in a nursing facility *(covered by TennCare outside the MCOs and BHOs)*			

**Effective July 1, 1998, pharmacy services for mental health and substance abuse drugs are managed and paid for by TennCare outside the BHOs.*

The "scope of benefits" provided in the EPSDT Consent Decree (see Section 54) includes the above services. The Consent Decree list is taken from federal statute, which is oriented more toward *types of service providers* than *types of services*. The list from the Consent Decree list is provided below, and services are cross-referenced to the services identified in the above chart.

(a) Inpatient hospital services (other than services in an institution for mental diseases)—see #1.
(b) Outpatient hospital services; rural health clinic services; and services offered by a federally qualified health center—see #3, #4, #8, #21.
(c) Other laboratory and X-ray services—see #9.

(d) EPSDT services, and family planning services and supplies—for EPSDT services, see all services listed in chart; for family planning services and supplies, see #5, #7, #17, #21.

(e) Physicians' services; medical and surgical services furnished by a dentist—see #5, #6, #7, and #12.

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law—see all services listed in chart.

(g) Home health care services—see #14.

(h) Private duty nursing services—see #28.

(i) Clinic services—see #3, #4, #8, #21, #26, and #32.

(j) Dental services—see #12.

(k) Physical therapy and related services—see #5, #7, and #21.

(l) Prescribed drugs, dentures, and prosthetic devices; eyeglasses—see #13, #15, and #17.

(m) Other diagnostic, screening, preventive, and rehabilitative services—see #23, #24, #25, #26.

(n) Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases)—see #35.

(o) Inpatient psychiatric services for individuals under 21—see #2.

(p) Services furnished by a nurse-midwife—see #5, #7, and #21.

(q) Hospice care—see #11.

(r) Case management services and TB-related services—for case management services, see #30; for TB-related services, see #1, #3, #5, #7, #9, #15, #17, and #21.

(s) Respiratory care services—see #14.

(t) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner—see #5, #7, #10.

(u) Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease—see #24.

(v) Any other medical care, and any type of remedial care recognized under state law, specified by the Secretary of the United States Department of Health and Human Services—see all services on above chart.

Attachment C

Useful Telephone Numbers

Useful Telephone Numbers

TennCare Information Line
1-800-669-1851 (741-4800 in the Nashville area)

TennCare TDD (hearing impaired)
1-800-772-7647 (313-9240 in the Nashville area)

TennCare Spanish-speaking Information Line
1-800-254-7568 (227-7568 in the Nashville area)

TennCare Solutions (for appeals)
1-800-878-3192 (253-4479 in the Nashville area)

TennCare Consumer Advocacy Line
1-800-722-7474 (313-9972 in the Nashville area)

TennCare Partners Mental Health and Substance Abuse Information Line
1-800-758-1638 (242-7339 in the Nashville area)

TennCare Bureau Office
(615) 741-0213

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Attachment D

Glossary

Glossary

BHO Behavioral Health Organization
a TennCare organization that delivers mental health and substance abuse treatment services

CFR Code of Federal Regulations
document containing federal regulations for programs such as Medicaid

CRG Clinically Related Group
a cagegory of individuals 18 and older who have serious mental health service needs

DCS Department of Children's Services
the department of State government which oversees the care of children in state custody and at risk of state custody

DHS Department of Human Services
the Department of State government which performs Medicaid eligibility determinations through its 95 county offices

EPSDT Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
a federal program that requires a comprehensive array of screening, referral, and treatment services for Medicaid-eligible children under the age of 21

HCBS Home and Community Based Waiver Services
a type of Medicaid waiver that offers home and community based services to a special population who would otherwise be eligible for institutional placement

HCFA Health Care Financing Administration
the federal agency which oversees the Medicaid and Medicare programs in all 50 states

ICF/MR Intermediate Care Facility for the Mentally Retarded (ICF/MR)
the federal designation for certain residential facilities serving persons with mental retardation

MCO Managed Care Organization
a TennCare organization that provides all health services except for mental health and substance abuse treatment services and long-term care services

PCP	Primary Care Provider *the individual in an enrollee's MCO who is responsible for coordinating his or her care*
SED	Seriously Emotionally Disturbed *a term applied to children under age 18 who have serious mental illnesses and severe functional impairments. The term does not apply to children in legal custody of the Department of Children's Services.*
SPMI	Severely and Persistently Mentally Ill *a term applied to persons age 18 and older who have serious mental illnesses and severe functional impairments.*
SSI	Supplemental Security Income *a federal cash assistance program for eligible individuals*
TPG	Target Population Group *a category of individuals under age 18 who have serious mental health service needs*

Attachment E

EPSDT Coordinators

EPSDT COORDINATORS

Access MedPLUS	Larry Harrison	Phone: (615) 255-2700 ext. 1290 Fax: (615) 313-2392 Email: Lharrison@accesshealth.net
BlueCare	Jennifer Atterton	Phone: (423) 763-3485 Fax: (423) 763-3248 Email: Jennifer Atterton@BCBST.com
John Deere	Barry J. Lindeman	Phone: (865) 769-1544 Fax: (865) 690-1941 Email: lindemanbarryj@jdcorp.deere.com
OmniCare	Vicki Bouscher	Phone: (901) 348-2207 Fax: (901) 348-2211 Email: Vbousch@ochptn.com
	Copy to: Catherine Green, Provider Services	Phone: (901) 348-3317
Xantus Health Plan	Jackie Heathington	Phone: (615) 463-1666 ext. 5570 Fax: (615) 279-1275 Email: Jheathington@xantushealthplan.com
PHP	Mary Cogar	Phone: (865) 670-7338 Fax: (865) 470-7404 Email: mdcogar@covhlth.com
TLC	Mia Earl	Phone: (901) 725-7100 ext. 3171 Fax: (901) 725-2846 Email: mearl@mmcc-tlc.com
Vanderbilt	Beverly Morckel	Phone: (615) 782-7800 ext. 3994 Fax: (615) 782-7822 Email: bmorckel@health23.com
Premier/TBH	Melissa Isbell	Phone: (615) 743-2115 Fax: (615) 743-2131 Email: MTIsbell@magellanhealth.com

January 2001

ATTACHMENT D
INTERAGENCY AGREEMENT

INTERAGENCY AGREEMENT

AMONG

TENNESSEE DEPARTMENT OF EDUCATION,

TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION

Bureau of TennCare, and

Division of Mental Retardation Services,

TENNESSEE DEPARTMENT OF HEALTH,

TENNESSEE DEPARTMENT OF HUMAN SERVICES, and

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

November 1, 2000

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Article One

Parties to Agreement

This Interagency Agreement (Agreement) is entered into by the Tennessee Department of Education (DOE), the Tennessee Department of Children's Services (DCS), the Tennessee Department of Finance and Administration (TDFA) Bureau of TennCare and Division of Mental Retardation Services (DMRS), the Tennessee Department of Health (DOH), the Tennessee Department of Human Services Division of Rehabilitation Services (DHS/DRS), and the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD). This includes all offices, divisions, bureaus, units and programs referred to in this Agreement for which each Department provides oversight.

Article Two

Purpose

This Interagency Agreement is intended to fulfill the requirements of Part B and Part C of the Individuals with Disabilities Education Act, 20 U.S.C. §1400 *et seq.* (IDEA). The purpose of this Agreement is to identify and define the financial responsibilities of the Parties to this Agreement and to facilitate the provision and coordination of services for all infants, toddlers, children, youth and adolescents who are IDEA eligible. This Agreement formalizes policies, procedures, and fiscal responsibilities of the Parties. For purposes of this Interagency Agreement, the term "child with a disability" shall always be defined according to 34 CFR §300.7(a) unless otherwise specified.

Article Three

Definitions

For purposes of this Interagency Agreement,

1. **"Assessment"** for Part B purposes, means the collection and integration of information to determine a student's current level of emotional, behavioral, academic, and intellectual functioning, educational needs, and strategies for remediation to promote effective treatment. *Special Education Dictionary.* For Part C purposes, it means the ongoing procedures used by qualified personnel throughout the period of a child's eligibility under Part C to identify: (a) the child's unique strengths and needs and the services appropriate to meet those needs; and (b) the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability. *34 CFR §303.322(b)(2).*

2. **"Behavioral health organization" (BHO)** means a type of managed care organization approved by TennCare or by a designee of TennCare to deliver mental health and substance abuse services to TennCare enrollees. *Tenn. Rule 1200-13-12-.01(2).*

3. **"Child Find"** means the collective name for Tennessee's policies and procedures, coordinated with all other major efforts conducted by Participating Agencies, designed and implemented to ensure that all children with disabilities (including children with disabilities attending private schools; underserved populations such as children in rural and urban areas;

and highly mobile children with disabilities (e.g. migrant and homeless children) residing in Tennessee, regardless of the severity of their disability, and who are in need of early intervention services or special education and related services, are identified, located, and evaluated. Child Find includes the process developed and implemented to determine which children are currently receiving early intervention services or special education and related services. *34 CFR §300.125 & 303.321.*

4. **"Child with a disability"** for IDEA purposes, means a child evaluated as having mental retardation, a hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, an emotional disturbance, an orthopedic impairment, autism, traumatic brain injury, other health impairment, specific learning disability, deaf-blindness, or multiple disabilities consistent with IDEA and in need of special education and related services. *34 CFR §300.7(a).*

5. **"Contract facility"** for DCS purposes, means a facility that contracts with the State to provide treatment and/or residential services to children in DCS custody. *DCS Glossary p. 7.*

6. **"Custody"** means the control of actual physical care of the child and includes the right and responsibility to provide for the physical, mental, and moral well-being of the child. *TCA §37-1-102(b)(8).*

7. **"Detention center"** means a place of confinement for juveniles in a secure or closed type of facility which is under the direction or supervision of the court or a facility which is designated by the court or other authority as a place of confinement for juveniles. *TCA §37-1-102(13).*

8. **"Developmental center"** means a facility certified by the Department of Health or the Department of Mental Health and Developmental Disabilities as an ICF-MR, which may be further defined in TCA Title 33.

9. **"Early intervention system"** means the total effort in Tennessee that is directed at meeting the needs of children eligible under IDEA Part C and their families. *34 CFR §303.11.*

10. **"Early Periodic Screening, Diagnosis and Treatment"** (EPSDT) means screening in accordance with professional standards, interperiodic screening, and diagnostic services to determine the existence of physical or mental illness or conditions in recipients under age 21; and health care, treatment, and other measures described in 42 USC §1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered. *Tenn.Rule 1200-13-12-.01(38).*

11. **"Education records"** mean those records, files, documents, and other materials which contain information directly related to a student and are maintained in an educational agency or institution or by a person acting for such agency or institution which are not specifically excluded under the five categories of exceptions set out in 20 USC §1232g(a)(4)(B) (FERPA - Exceptions).

12. **"Emergency medical condition"** for TennCare purposes, means a medical condition that manifests itself by symptoms of sufficient severity (including severe pain) that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the person's health (or, with respect to a pregnant woman, potentially her unborn child's) in serious jeopardy; (b)

serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. *Tenn. Rule 1200-13-12-.01(12).*

13. **"Evaluation"** for the purposes of Part B, means procedures used to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs. *34 CFR §300.500(b)(2).* For Part C purposes, it means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility, consistent with the definition of "infants and toddlers with disabilities" in Tennessee, including determining the status of the child in each of the following developmental areas: (a) cognitive development; (b) physical development, including vision and hearing; (c) communication development; (d) social-emotional development; and (e) adaptive skills. *34 CFR §303.322(b)(1).*

14. **"Family Educational Rights and Privacy Act"** (FERPA) means the collective name for federal legislation prohibiting educational agencies or institutions from releasing education records of students unless consistent with the terms of the Act. *20 U.S.C. § 1232g.*

15. **"Foster care"** means the temporary placement of a child in the custody of DCS or any agency, institution, or home, whether public or private, for care outside the home of a parent or relative (by blood or marriage) of the child, whether such placement is by court order, voluntary placement agreement, surrender of parental rights or otherwise. Foster care shall cease at such time as the child is placed with an individual for the purpose of the child's adoption by the individual or at such time as a petition to adopt is filed, whichever occurs first, or at such time as the child is returned to or placed in the care of a parent or relative. *TCA §37-2-402(5).*

16. **"Foster home"** means a private home which is approved by DCS or other licensed child-placing agency and provides full time care for up to six (6) children at one time. This maximum includes birth, adopted or foster children. *DCS Glossary p. 14.*

17. **"Free appropriate public education"** (FAPE) means regular and special education and related services which:

(a) Are provided at public expense, under public supervision and direction, and without charge to the parent;

(b) Meet the standards established by state law, including the requirements of IDEA Part B and the *Rules, Regulations and Minimum Standards for the Governance of Tennessee Public Schools,* issued by DOE;

(c) Include preschool, elementary school, and secondary school (including appropriate vocational, career or work experience education) and

(d) Are provided in conformity with an individualized education program (IEP). *34 CFR §300.13.*

18. **"*Grier* Revised Consent Decree"** means the consent decree *Grier v. Wadley,* U.S. Dist. (M.D. Tenn.) Civil Action No. 79-3107 entered October 26, 1999.

19. **"ICC"** means the State Interagency Coordinating Council. *34 CFR §303.600.*

20. **"Individuals with Disabilities Education Act"** (IDEA) means the collective name for federal legislation codified at 20 USC §1400 *et seq.* as amended, providing federal funds for special education and related services and early intervention services to children with disabilities in accordance with standards set by the Act.

21. **"Individualized Education Program"** (IEP) means a written statement that is developed, reviewed, and revised in a meeting of the IEP Team, in accordance with 34 C.F.R. §§ 300.341-300.350 (IEP), for a child with a disability who qualifies for special education and related services under IDEA Part B.

22. **"Individualized Education Program Team"** (IEP Team) means a statutorily defined group of individuals under 34 C.F.R. § 300.344 (IEP Team), with the responsibility for determining eligibility and/or special education and related services under IDEA Part B.

23. **"Individualized Family Service Plan"** (IFSP) means a written plan for providing early intervention and other services to an infant or toddler with a disability and his family under IDEA Part C which:

(a) Is developed jointly by the family and appropriate qualified personnel involved in the provision of early intervention services;
(b) Is based on the multidisciplinary evaluation and assessment of the child and the assessment of the child's family;
(c) Includes services necessary to enhance the development of the child and the capacity of the family to meet the special needs of the child;
(d) Contains a statement of the natural environment in which early intervention services shall appropriately be provided, including a justification of the extent, if any, to which the services will not be provided in a natural environment; and
(e) Is reviewed by interactive means acceptable to all parties, and at least on a six month interval. *34 CFR §303.340(b) & 303.344.*

24. **"Individual Support Plan"** (ISP) means a written document central for planning, providing and reviewing the supports and services to be provided by DMRS through its contract agencies for those in the Home and Community Based Services (HCBS) waiver. *DMRS's Family Handbook p. 30.*

25. **"Infant or Toddler with a Disability"** means an individual birth to age three who qualifies for early intervention services under IDEA Part C because he/she:

(a) Is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development; physical development, including vision and hearing; communicative development; social or emotional development; adaptive development; or
(b) Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay; or
(c) Exhibits developmental delays for which there are no standardized measures or for which existing standardized procedures are not appropriate for the child's age or a given developmental area.

This child may, in accordance with procedures established by DOE, be deemed eligible by an Informed Clinical Opinion. *34 CFR §303.16.*

26. **"Intra-agency dispute"** means the inability of divisions, offices, bureaus, units or programs within a department or agency to agree as to which is responsible for coordinating services; providing appropriate services; paying for appropriate services or any other matter related to the department's or agency's statutory responsibilities.

27. **"Interagency dispute"** means any disagreement between two or more Participating Agencies concerning the responsibility for coordination of services, provision of appropriate

services, payment for appropriate services or any other matter related to this Agreement for an eligible child under IDEA Part B and C.

28. **"*John B.* Consent Decree"** means the consent decree *John B. v. Menke*, U.S. Dist. (M.D. Tenn.) Civil Action No. 0168, entered March 11, 1998.

29. **"Least restrictive environment"** means to the maximum extent appropriate, an environment where children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are nondisabled. *34 CFR §300.550 (b)(1).*

30. **"Local educational agency"** (LEA) means a public board of education or other public authority legally constituted within Tennessee for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of Tennessee, or for a combination of school districts or counties that are recognized in Tennessee as an administrative agency for its public elementary or secondary schools. *34 CFR §300.18(a).*

31. **"Managed Care Organization"** (MCO) means an appropriately licensed HMO approved by the TDFA/Bureau of TennCare as capable of providing medical services in the TennCare program. *Tenn. Rule 1200-13-12-.01(24).*

32. **"Medical assistance"** as used in the TennCare Rules and for purposes of this Agreement, means care, services, drugs, equipment, and supplies prescribed as medically necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, or interfere with or threaten some significant impairment and which are furnished in accordance with Title XIX of the Social Security Act (Medicaid) and T.C.A. §71-5-101 *et seq.* (Welfare-Programs and Services for Poor Persons-Medical Assistance). Such care, services, drugs, and supplies shall include services of qualified practitioners licensed under the laws of the State of Tennessee. *TCA §71-5-103(5).*

33. **"Medical services"** means services provided by a licensed physician to fulfill the requirements of IDEA in order to determine a child's medically related disability that results in the child's need for special education and related services. *34 CFR §300.24(b)(4).*

34. **"Medically necessary"** means services or supplies provided by an institution, physician, or other provider which are required to identify or treat a person's illness or injury and which are:

(a) Consistent with the symptoms or diagnosis and treatment of the person's condition, disease, ailment, or injury; and

(b) Appropriate with regard to standards of good medical practice; and

(c) Not solely for the convenience of a person, physician, institution or other provider; and

(d) The most appropriate supply or level of services that can safely be provided to the person. When applied to the care of an inpatient, it further means that services for the person's medical symptoms or condition require that the services cannot be safely provided to the person as an outpatient.

(e) When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. *Tenn. Rule 1200-13-12-.01(26).*

35. **"Natural environments"** for IDEA Part C purposes, mean settings that are natural or normal for a child's age peers who have no disability. *34 CFR §303.12(b)(2).*

36. **"Parent,"** for IDEA purposes, means—

(a) A natural or adoptive parent of a child;

(b) A guardian but not the State if the child is a ward of the state;

(c) A person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare); or

(d) A surrogate parent who has been appointed in accordance with 34 C.F.R. § 300.515 (Surrogate Parents). *34 CFR §300.20(a).*

A foster parent may act as a parent if—

(a)The natural parent's authority to make educational decisions on the child's behalf has been extinguished under Tennessee law; and

(b) The foster parent--

(i) Has an ongoing, long-term parental relationship with the child;

(ii) Is willing to make the educational decisions required of parents under the IDEA; and

(iii) Has no interest that would conflict with the interests of the child.

34 CFR §300.20(b).

37. **"Participating Agencies"** means the Tennessee Department of Children's Services, the Tennessee Department of Education, the Tennessee Department of Finance and Administration/ Bureau of TennCare, and the Division of Mental Retardation Services, the Tennessee Department of Health (Part C only), the Tennessee Department of Human Services/Division of Rehabilitation Services (Part B only),, and the Tennessee Department of Mental Health and Developmental Disabilities.

38. **"Payor of last resort"** means the agency that has ultimate responsibility for providing a service for a child with a disability or his family after all other potential resources have been exhausted.

39. **"Permanency planning"** means the process of intervention and decisive casework on the part of the DCS case manager. Such intervention focuses on choosing the least restrictive permanent outcome for the child, i.e. return to parent, relative placement, adoption, independent living or permanent foster care, in a timely manner. *DCS Glossary p. 23.*

40. **"Personally identifiable information"** means the information that relates to or concerns an individual student. It includes but is not limited to the student's name, the name of the student's parent(s) or other family member(s), the address of the student or student's family, a personal identifier such as the student's social security number or student number, and a list of personal characteristics that would make the student's identity easily traceable. *34 CFR §300.500(b)(3).*

41. **"Primary care physician"** (PCP) means physicians who have limited their practice of medicine to general practice, or physicians who are Board Certified or Board Eligible in any of the following: Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Family Practice. *Tenn. Rule 1200-13-12-.08(10)(b)(1)(I).*

42. **"Primary referral sources"** means hospitals (including prenatal and postnatal care facilities), physicians, parents, day care programs, LEAs, public health facilities, other social services agencies, and other health care providers. *34 CFR §303.321(d)(3).*

43. **"Regional Mental Health Institute"** (RMHI) means a mental health facility or institution of the State of Tennessee over which TDMHDD has exclusive jurisdiction and control. *TCA §4-3-1603(a).*

44. **"Related services"** means transportation and such developmental, corrective, and other supportive services that are required to assist a child with a disability to benefit from special education. It includes speech-language pathology and audiology services; psychological services; physical and occupational therapy; recreation, including therapeutic recreation; early identification and assessment of disabilities in children; counseling services, including rehabilitation counseling; orientation and mobility services; and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training. *34 CFR §300.24(a).*

45. **"Residential facility"** means a facility that offers twenty-four (24) hour residential care as well as a treatment and habilitation component.

46. **"Runaway house/shelter"** means any house or institution, operated by DCS, giving sanctuary or housing to any person under eighteen (18) years of age who is away from home or the residence of his/her parent without the parent's consent. *TCA §37-2-502(3).*

47. **"School health services"** means services provided in school or at school sponsored events by a qualified school health nurse or other qualified health care professional. *34 CFR §300.24(b)(12).*

48. **"Service coordinator"** means the individual appointed by a public agency or selected by the IFSP team and designated in the IFSP to carry out service coordination activities. Service coordinators shall have demonstrated knowledge and understanding about: IDEA eligibility; IDEA Part C; the nature, scope, and availability of services within the early intervention system; the system of payments for early intervention services; and other pertinent information. *34 CFR §303.22.*

49. **"Special education"** means specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability, including (i) instruction conducted in the classroom, in the home, in hospitals, in institutions, and in other settings; and (ii) instruction in physical education. *34 CFR §300.26(a).*

50. **"Surrogate parent"** means a person appointed when a child is a ward of the state or when the parent or legal guardian is unable to be located after reasonable efforts by the public agency. For IDEA purposes, the surrogate parent may represent a child in all matters relating to: (a) the identification, evaluation, and educational/early intervention placement of the child; and (b) the provision of FAPE/early intervention services to the child. *34 C.F.R. § 300.515(a) & (e).*

51. **"TennCare"** is the program by which the State of Tennessee provides medical assistance to persons eligible for Title XIX of the Social Security Act (Medicaid), to uninsured children under the age of nineteen (19), and to uninsured persons of any age who have been denied health insurance because of a health problem. References to TennCare shall also include

reference to the Bureau of TennCare, TennCare Partners, and any other agencies, public or private, contractors and subcontractors through whom TennCare provides medical benefits. *Tenn. Rules 1200-13-12-.01(3) & .02(a).*

52. **"TennCare enrollee"** means any TennCare eligible person who has enrolled in a MCO authorized to provide services in the geographical area where the person resides. Persons enrolled in TennCare are automatically enrolled in the TennCare Partners Program and will be served by the BHO partnered with the MCO in which the person has enrolled. *Tenn. Rules 1200-13-12-.01(13) & 1200-13-12-.02(8)*

53. **"TennCare provider"** means an institution, facility, agency, person, corporation, partnership, or association which accepts, as payment in full for providing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with a MCO. Such payment may include fees, deductibles, copayments, special fees or any combination of these. *Tenn. Rules 1200-13-12-.01(28).*

54. **"Tennessee Early Intervention System"** (TEIS) means a network of nine district offices established by DOE that provides access under IDEA Part C to early intervention services statewide. TEIS offers a wide range of services from which an individualized program can be designed to meet the unique needs of each child and family.

55. **"Transition services"** for IDEA Part B, means a coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school to post-school activities, including postsecondary education, vocational training, integrated employment including supported employment, continuing education, adult education, adult services, independent living, and community participation. *34 CFR §300.29 & Rehabilitation Act of 1973 as amended, §7(37).*

56. **"Vocational rehabilitation services"** means any services described in an individualized plan for employment necessary to assist an individual with a disability in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual. *Rehabilitation Act of 1973 as amended, §103.*

57. **"Youth Development Center"** (YDC) means a secure facility, operated by DCS, for those who have been adjudicated delinquent and meet the criteria established by DCS for placement at such facility. *TCA §37-5-103(16).*

Article Four

IDEA PART B SERVICES

A. Tennessee Department of Education

a. Division of Special Education

1. DOE will coordinate the provision of services under this Agreement to ensure that children who are IDEA eligible receive FAPE in the least restrictive environment.

2. The use of an interagency agreement does not alter or diminish the responsibility of DOE to ensure compliance of all public agencies serving children with disabilities with the requirements of IDEA. This will be accomplished through compliance monitoring.

3. Each LEA will file with DOE an annual comprehensive plan for providing special education and related services to children with disabilities who reside within its jurisdiction. DOE will ensure that the comprehensive plan is in compliance with IDEA Part B and all state and federal statutes and regulations. It shall be the responsibility of the LEA or responsible state agency to determine eligibility, provide the appropriate special education and related services, and to fulfill the requirements of IDEA Part B for all children who are IDEA eligible. *34 CFR §300.320(a).* If DOE determines that a LEA or responsible state agency is unable to meet its obligations under IDEA, DOE shall use IDEA Part B funds that would otherwise have been available to a LEA or state agency and provide or cause to be provided special education and related services directly to children who are IDEA eligible formerly served by the LEA or state agency. *34 CFR §300.360(a).*

4. Any state agency or private school shall comply with the Tennessee Department of Education's *Rules, Regulations, and Minimum Standards for the Governance of Tennessee Public Schools* in the establishment of an educational program. Any facility or LEA that serves a child who is IDEA eligible must also meet the standards established by IDEA and TCA §49-10 (Special Education). DOE will monitor all state agencies providing educational programs, and private schools to ensure compliance with applicable federal and state regulations. Each facility will be monitored on a three (3) year cycle. One year prior to being monitored, all agencies or private schools will be provided technical assistance by DOE. DOE shall then conduct an on-site review of the educational program at the facility or school. Once the review is complete, DOE generally issues a report within thirty (30) calendar days. The report shall include commendations, recommendations, and exceptions that need to be corrected to bring the program in compliance with IDEA and all other applicable state and federal laws and regulations. When exceptions are identified, the facility or school shall be required to provide a corrective action plan (CAP) to DOE within thirty (30) calendar day of the receipt of the report. The corrective action plan shall outline steps and timelines for correcting the exceptions. DOE shall review the plan to assure that it is adequate to ameliorate the exceptions and will follow up with an on-site visit to ensure compliance.

5. DOE is responsible for maintaining a database of information provided by the LEAs on children with disabilities known as a census. DOE shall provide census information to the U.S. Department of Education as required by federal law.

6. DOE shall ensure that all due process hearings requested by parents to resolve issues of IDEA eligibility, placement, or the provision of FAPE will be conducted in accordance with all applicable state and federal statutes and regulations. DOE will maintain a list of state hearing officers and their qualifications. DOE shall appoint hearing officers. All due process hearings under IDEA shall be conducted consistently with state and federal law. *TCA §49-10-601.*

7. In accordance with IDEA, DOE will investigate all administrative complaints filed by parties as it relates to compliance and provision of special education and related services for children who are IDEA eligible. Within sixty (60) calendar days of receipt of a complaint, DOE will conduct an independent investigation; give the complainant an opportunity to submit additional information; and make an independent determination of the issue. DOE will issue a written decision that addresses each of the complainant's allegations and contains findings of fact and conclusions of law as well as the reasons for its final decision. When appropriate, DOE shall conduct on-site investigations to gather additional data and resolve complaints. Upon request and as deemed necessary by DOE, DOE will grant extension to sixty (60) calendar days for the resolution of the complaint in order for the parties to submit additional information. *34 CFR §300.661.*

8. Upon request and with the consent of both the parent and the LEA, DOE will assign a mediator to resolve disputes arising under IDEA. DOE will appoint mediators and provide them with training in mediation and special education law. Consent to mediation by the parent of a child who is IDEA eligible is voluntary and will not delay or deny a parent's right to a due process hearing nor shall it deny parents any other rights afforded them under IDEA Part B. DOE shall bear the cost of the mediation process. Consistent with IDEA, all discussions that occur during the mediation process must be confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings. The parties to the mediation process are required to sign a confidentiality pledge prior to the commencement of the process. *34 CFR §300.506.*

9. DOE shall administer the Systems Change Transition Grant. To receive this grant, the LEA must submit an application to DOE with a proposal for transition services to be provided by the LEA. If accepted, DOE will furnish the LEA with funds to implement the Transition Services proposed in the application. Transition specialists from DOE shall monitor the programs and provide the LEAs with technical assistance as needed. Transition specialists will provide these services to LEAs who are receiving grant funds as well as those that are not. The Systems Change Transition Grant is a one time one year grant to provide seed money for transition services. After the one year grant ends, the Transition Program should be sustainable by the LEA.

10. DOE encourages LEAs to participate in the School to Work Case Manager's Grant Program administered by DHS/DRS. This grant provides the LEA with federal funding to employ a transition case manager to work with DHS/DRS eligible students in the LEA. The LEA is required to provide state or local match dollars. *See Article 4 Section G - DHS/DRS.*

11. DOE has developed a departmental policy which allows for the reimbursement of the LEA for sixty to one hundred percent (60%-100%) of the cost for services provided to high cost/medically fragile children based on the availability of federal funds within any given fiscal year. Criteria established by DOE will be used to determine the priority of disbursement of funds. To apply for these funds, the LEA shall file a request with DOE for reimbursement. The request shall be reviewed by the Assistant Commissioner of the Division of Special Education or his/her designee. The funds shall be distributed to the LEA based on special education expenditures from the General Purpose School Fund and not IDEA Part B, and/or

Preschool Grant funds. The DOE/Division of Special Education shall make the final decision regarding the amount of reimbursement and allotment of funds.

12. DOE, in conjunction with the other Participating Agencies as appropriate, shall provide technical assistance and training to the LEAs as it relates to the billing of other public agencies that are providing services to children who are IDEA eligible and provide any other training and assistance as necessary. For this purpose, DOE will be responsible for coordinating the provision of services with LEAs through the state's Regional Resource Centers to be supported by the Participating Agencies. These Regional Resource Centers will provide technical assistance to LEAs in areas such as evaluation, appeals, best practices, reporting procedures, appropriate provision of special education and related services for individual children, and any other identified areas as needed.

13. DOE shall furnish TennCare/EPSDT providers with criteria and training concerning IDEA requirements. TennCare will train TennCare/EPSDT providers concerning EPSDT requirements. TennCare will ensure that MCOs provide appropriate technical assistance to TennCare providers in billing and the coordination of services for children who are IDEA eligible. This training will be conducted annually and will begin within ninety (90) after this Agreement has become final.

14. Through state statute, Tennessee has extended eligibility for special education and related services to children identified as functionally delayed in accord with *Rules, Regulations, and Minimum Standards for the Governance of Tennessee Public Schools.* Although not entitled to services under IDEA, a child identified as functionally delayed is considered a child with a disability for purposes of this Agreement and shall receive the same services and protections as a child with a disability under IDEA.

b. Local Educational Agency

1. When the local educational agency (LEA) finds or suspects that a child may be eligible for special education and related services under the IDEA, the LEA, with the permission of the parent or legal guardian, shall secure an appropriate evaluation to determine if a child is eligible for special education and related services. If the child is a TennCare enrollee, the LEA, with the permission of the child's parent or legal guardian, may refer the child for an EPSDT screen. *See Article 4 Section C – TennCare.* When a LEA suspects that a TennCare enrolled child may have a particular medical or behavioral health problem and the child is up-to-date on his EPSDT screenings, the LEA should refer the child to the child's PCP for an EPSDT interperiodic screen. However, the LEA must complete the evaluation process within the timelines promulgated by DOE in *Rules, Regulations and Minimum Standards for the Governance of Tennessee Public Schools.* This provision does not alter the timeliness requirements for EPSDT screens by which the MCOs are bound.

2. Parents of students who are IDEA eligible and students referred for an IDEA eligibility evaluation will be asked to complete a voluntary form to indicate if the child is receiving services from any other Participating Agency. All information provided by the parents of a child who is IDEA eligible is voluntary and will be used only to ensure compliance with IDEA. IDEA services provided by the LEA to children who are IDEA eligible will not be reduced nor will IDEA eligibility be affected if the child is enrolled in the TennCare program. TennCare may not disqualify a medically necessary covered service for reimbursement because that

service is provided in accordance with an IEP. *34 CFR §300.142(b)(1)(i).* Individual TennCare information such as MCO, BHO, PCP, and related medical information shall be kept strictly confidential as required by FERPA, IDEA, and all applicable state and federal law. Such information will only be used by the LEA to coordinate the appropriate special education, related services, and medically necessary services for each IDEA and TennCare enrolled child. All records and information shall only be disclosed to the extent allowed by IDEA, FERPA, and all other applicable state and federal laws. *See Article 7 - Records.* When a child identified as IDEA eligible is also a TennCare enrollee, the LEA will ask the parent to notify the child's PCP and MCO that the child is receiving special education and has an IEP. The LEA shall also request that the parent agree to share the child's IEP with his/her PCP and MCO. TennCare has developed a release form to help facilitate the disclosure of the IEP to the PCP so that they can help these children receive medically necessary TennCare services, if appropriate. *See Attachment 3 - TennCare Release Form.*

3. In order to ensure that FAPE is provided to eligible children at no cost to parents, parents shall not be required to use private insurance to pay for special education and related services. *34 CFR §300.142(f).* The use of private insurance must be voluntary and the parents must consent. If a parent elects to access private insurance, the LEA may pay the family's copayment assessed by the insurance company using Part B funds. If a TennCare enrollee is assessed a copayment, the LEA may pay that copayment to ensure that FAPE is provided to children with disabilities at no cost to parents.

4. Services and evaluations for children who are IDEA eligible must be provided within a reasonable time period. *34 CFR §300.142(b)(2).* In order to provide special education and related services in a timely and efficient manner to students who are IDEA eligible, a LEA may contract with appropriate providers or provide the needed services itself. If the child is a TennCare enrollee, the MCO shall accept the IEP indication of a medical problem or shall have the child appropriately tested. *John B* Consent Decree *at p. 42.* TennCare will provide all medically necessary covered medical services and all EPSDT screens and interperiodic screens that the child may need. If the child is a TennCare enrollee and non-emergency medical services are provided by the LEA, the LEA must be a TennCare provider in order to seek reimbursement for these services from TennCare consistent with policies and procedures adopted by TennCare, DOE, and this Agreement.

5. Once a child is evaluated, the LEA will convene an IEP Team meeting to determine if the child is eligible to receive special education and related services. If eligibility is determined, the IEP Team will create an appropriate IEP. The special education teacher or person responsible for facilitating the IEP Team meeting will send an invitation to the child's parents and will send a copy of the invitation or personally call representatives from other agencies to participate in the IEP Team meeting if the other agencies may be required to provide services listed in a child's IEP. The LEA will provide all special education or related services to children with disabilities that are part of the IEP and necessary for FAPE in the least restrictive environment. *34 CFR §300.343*

6. All LEAs and Participating Agencies that have chosen to provide special education and related services to IDEA eligible children in contract facilities within the State of Tennessee must ensure the facility meets the requirements set forth in *Rules, Regulations, and Minimum Standards for the Governance of Tennessee Public Schools.* DOE shall monitor these facilities for compliance with IDEA and other state and federal regulations. *See Article 4 Section A - DOE.* An IEP Team meeting must be convened for children who are IDEA eligible educated in a contract facility. The contract facilities agree to provide the services listed in a child's IEP

that would be provided by the LEA in a public school. The LEA is responsible for the educational costs related to the provision of special education and related services for the child attending school in the contract facility if the LEA placed the child in the facility. If a parent enrolls a child who is IDEA eligible in a contract facility, the facility is considered a private school, and the special education and related services costs are the parent's responsibility. The financial responsibility of other Participating Agencies who are providing services in the child's IEP shall not be altered because the child who is IDEA eligible is being educated at a contract facility when placed there by the IEP Team.

7. When a child who is IDEA eligible reaches the age of fourteen (14), the IEP Team shall formulate an ITP (Individualized Transition Plan) that will include the transition service needs of the child. The LEA shall provide functional and vocational assessments as needed that will assist the IEP Team in formulating an appropriate ITP. The ITP will focus on the child's course of study while in school. The special education teacher or person responsible for facilitating the IEP Team meeting will send a copy of the invitation sent to the parents and child or personally call a representative from DMRS, DHS/DRS, DCS, and other agencies, as appropriate, and invite them to the IEP Team meeting. The ITP will be updated annually. *34 CFR §300.347(b)(1).* The child must be invited to the meeting. If the student is not in attendance, documentation must be presented and considered concerning his preferences and interests.

8. When a child who is IDEA eligible reaches the age of sixteen (16), or younger if determined appropriate by the IEP Team, the ITP will include a statement of needed transition services as well as the agency responsible for providing and paying for the services. *34 CFR §300.347(b)(2).* If the IEP Team determines that the student should be referred to DHS/DRS for vocational rehabilitation services, the student must be present at the IEP team meeting when the referral is made.

9. As part of the IEP Team process, the LEA shall facilitate the transition from special education and related services to vocational rehabilitation services. Therefore, the LEA will provide DHS/DRS with the child's last psychological report and information about the student's ability to obtain and maintain employment, functional inventories and performance reports on community/work-based learning experiences. All of the information and data supplied by the IEP Team which documents successful community job training experiences will supplement any evaluations DHS/DRS might choose to perform. All evaluations provided by the LEA to DHS/DRS for vocational rehabilitation eligibility determinations shall be considered confidential education records consistent with IDEA, FERPA, and all applicable federal and state laws. *See Article 7 - Records.*

10. If another public agency is obligated under federal or state law or assigned responsibility under State policy to provide or pay for any services that are also considered special education or related services and are necessary for ensuring FAPE to children who are IDEA eligible, the public agency shall fulfill that obligation or responsibility, directly, through contract or by another arrangement. *34 CFR §300.142(b).* If another public agency is responsible for services that are part of special education or related services listed in a child's IEP, the LEA will notify the other public agency by letter or by personal phone call of its financial responsibility for covering that service pursuant to applicable state and federal law or regulations and this Agreement. The LEA shall also send the public agency a copy of the IEP that pertains to the services in question. The LEA shall notify all public agencies that may have financial responsibility for special education and related services of the child's IEP Team meeting by sending a copy of the invitation sent to the parents or personal phone call. *34 CFR*

§300.344. The public agency that has financial responsibility for providing a child who is IDEA eligible with services shall not be relieved of that responsibility simply because an agency representative does not attend an IEP Team meeting. Additionally, the failure of that public agency to pay for that service shall not relieve the LEA of its obligation to provide that service to the child with a disability in a timely manner. *34 CFR §300.142(b)(2).* The LEA may seek reimbursement for the services for which the child is eligible under each agency's programs from the public agency that failed to provide or pay for these services. *Id.* In order for a LEA to seek reimbursement from TennCare or a MCO or BHO, the LEA must be a TennCare provider. If there is a dispute regarding reimbursement, the dispute shall be resolved in accord with the procedures outlined in Article 6 of this Agreement.

11. The LEA shall provide information to the parent of a child who is IDEA eligible on accessing services from other public agencies that may assist the parent in meeting the child's needs but which are not services under IDEA. If the school suspects that not all areas of the child's suspected disability have been addressed, it is the school's responsibility to address all the areas and contact other Participating Agencies, as necessary, unless the IEP states otherwise. The referral by the LEA representative on the IEP Team of a child to other public agencies shall not be considered a determination of eligibility or obligate the public agency to provide or pay for any service not in the child's IEP. The parent shall be responsible for meeting all eligibility requirements of other public agencies.

12. Beginning one year before a student reaches the age of majority (eighteen (18) in Tennessee), the student's IEP must include a statement that the student has been informed of his/her rights under IDEA that will transfer to the student upon reaching the age of majority. All rights will be transferred from the parent to the student upon reaching the age of majority unless the student has been declared incompetent under Tennessee law. *34 CFR §300.517.* However, nothing in this section prohibits the LEA from inviting a child's parent to an IEP Team meeting if the parent has special knowledge related to the student which may be helpful in determining appropriate special education and related services for the student who has reached the age of majority. *34 CFR §300.344(a)(6).*

B. Bureau of TennCare

1. TennCare contracts with MCOs to provide medical care through networks of subcontracted health providers. MCOs are paired with BHOs to create access to a network of providers for enrollees in need of mental health and substance abuse services. TennCare monitors MCOs and BHOs to ensure that they are in compliance with TennCare Rules and are providing accessible in-network providers to TennCare enrollees.

2. TennCare shall perform TennCare eligibility determinations for children who apply for TennCare and conduct EPSDT outreach to help TennCare enrollees receive medically necessary care consistent with *John B.* Consent Decree at pp. 15-18.

3. TennCare is responsible for providing EPSDT services for all children who are TennCare enrollees. EPSDT services include: (a) periodic well-child screenings in accordance with the recommendations of the American Academy of Pediatrics; (b) medically necessary health and behavioral health diagnostic services; and (c) medically necessary health and behavioral health treatment services. EPSDT treatment services include "such other necessary health care, diagnostic services, treatment and other measures [described in §1396d(a)] . . . to correct or to ameliorate defects and physical and mental illnesses and conditions discovered by the screening

services, whether or not such services are covered under the State Plan." *42 USC §1396d(r)(5); John B. Consent Decree at p. 5.* EPSDT services are based on the individual child's medical, developmental, and behavioral health needs. No prior authorization by the MCO is needed for a screen conducted by a PCP, and the MCO will provide all medically necessary covered services regardless of whether or not the need for such services was identified by a provider who received prior authorization or by an in-network provider. *John B. Consent Decree at p. 21.* TennCare (including its contractors, the MCOs and BHOs) cannot impose limitations on EPSDT services other than medical necessity. This means that the state cannot set arbitrary limits of duration, scope, or cost of services under EPSDT. *John B. Consent Decree at p. 33.* The MCOs and BHOs have the discretion to require that their network providers deliver TennCare covered services, as long as the networks are sufficient in size and scope to meet the access standards of the MCO/BHO's contract with the state.

4. Any encounter with a health professional practicing within the scope of his/her practice is an interperiodic screen. Any person such as an educator, parent, or health professional who suspects a health problem may refer a child for an interperiodic screen. An interperiodic screen does not have to include any screening elements required for a periodic screen. No prior MCO authorization is required for an interperiodic screen, and the MCO shall provide all medically necessary covered services identified by the interperiodic screen. *John B. Consent Decree at p. 23.*

5. LEAs, with parental consent, should refer TennCare enrolled children for EPSDT screenings when the child is not up to date on his/her screens. Neither the parent nor TennCare is required to inform the LEA that the child is a TennCare enrollee. The child's MCO will be responsible for identifying whether or not the child's screenings are up-to-date and shall be responsible for providing screenings as needed. The MCO may share this information with the LEA only with parental consent. These screens shall be provided by the child's PCP under contract with the MCO. When a LEA suspects that a TennCare enrolled child may have a particular medical or behavioral health problem and the child is up-to-date on his EPSDT screenings, the LEA should refer the child to the child's PCP for an EPSDT interperiodic screen. The PCP will make recommendations to the MCO/BHO if he/she believes there is a need for additional diagnosis and/or treatment that is medically necessary. *John B. Consent Decree at p. 38.*

6. TennCare will provide all covered medically necessary services, including durable medical equipment, for all children who are TennCare enrollees, regardless of whether or not these children are IDEA eligible. TennCare shall provide transportation to and from appointments for services covered by TennCare when the enrollee does not have access to transportation services. *John B. Consent Decree at pp. 41-2.* TennCare may not disqualify an eligible service for TennCare reimbursement because that service is provided in accord with an IEP. *34 CFR §300.142(b)(1)(i).* MCOs and BHOs have the discretion to require that covered services be delivered by providers in their networks, within the access standards required in their contracts with the state. There is no specific requirement that MCOs and BHOs provide services in the schools if these services can be delivered by the MCOs' or BHOs' qualified providers within the required access standards.

7. Children who are inmates are not covered by TennCare. *42 CFR §435.1008, 435.1009.* An inmate is defined as an individual confined for a criminal offense in a local, state, or federal prison, jail, youth development center, or other penal or correctional facility, including a furlough from such facility. Excluded from this definition are persons confined in a juvenile detention center. *Tenn.Rule 1200-13-12-.01(25).*

8. Emergency medical services are available twenty-four (24) hours per day, seven (7) days per week for TennCare enrollees. Coverage of emergency medical services is not subject to prior authorization by the MCO. *Tenn.Rule 1200-13-12-.04(4)*

9. Each TennCare MCO and BHO is responsible for the management of medical care and continuity of care for all its TennCare enrollees including children who are IDEA eligible. Specific responsibilities include performance of reasonable preventive health case management services, appropriate referral and scheduling assistance for enrollees needing specialty health care services, monitoring of enrollees with ongoing medical conditions, coordinated hospital and/or institutional discharge planning that includes post-discharge care as appropriate, maintenance of an internal tracking system which identifies the current preventive service screening status and pending due dates for each enrollee, and authorization of out-of -plan or out-of-state services which are medically necessary due to an emergency. *Contractor's Risk Agreement between TennCare and MCO September, 1995.* In addition, to coordinate EPSDT screens and services, each TennCare MCO/BHO shall provide case management services by assisting children for whom case management is medically necessary. *John B. Consent Decree at p. 38.* The case management provided shall center on the process of collecting information on the health needs of the child, making and following up on referrals as necessary, and activating the examination/diagnosis/treatment loop. *Id. at pp. 38-9.* The case management services must meet the needs of the child and cannot be used exclusively as a tool for prior authorization. *Id. at p. 39.*

10. TennCare shall coordinate the delivery of covered health and behavioral health services with services offered by other state health agencies and shall attempt to make use of other public health, mental health, and educational programs and related programs such as Head Start to ensure an effective child health program. TennCare shall inform the LEAs that MCOs are responsible for requesting the IEPs of enrollees who they know are children who are IDEA eligible and enrolled in each MCO. TennCare has developed a release form to provide to LEAs that a parent may use to consent to the release of education records consistent with IDEA, FERPA and all applicable state and federal regulations. The LEA is responsible for sharing the IEP with the PCP after obtaining appropriate parental consent. *See Attachment 3 - TennCare Release Form.* MCOs shall accept the IEP indication of a medical problem or shall have the child appropriately tested. Coordination by the MCO and LEA should be calculated to reduce gaps and overlaps in services. *John B. Consent Decree p. 42.*

11. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, delay, termination, suspension, or reduction of medical assistance by the MCO or BHO. Appeals will be handled in accordance with procedures outlined in applicable State rules and as required by the *Grier* revised Consent Decree. *TennRule 1200-13-12-.11.*

C. Tennessee Department of Children's Services

1. No child with a disability shall be denied special education and related services in the least restrictive environment because of his/her status as a child in state custody. For the purposes of DCS and this section of the Agreement, least restrictive environment means the placement that is no more restrictive than is necessary to meet the treatment and security needs of the student. *DCS Glossary p. 18.* As governed by IDEA, all educational placements, and special education, and related services decisions remain with the child's IEP Team when the child is placed in state custody.

2. Placement in DCS custody is court ordered due to dependency and neglect, unruliness or delinquency, and is not an educational placement. DCS develops a permanency plan for each child which includes education, behavior, personality, family and testing results. If the child is IDEA eligible or needs to be referred for testing, this will be indicated on the permanency plan.

3. The provision and cost of special education and related services for a child with a disability in DCS custody and living in a foster home shall be provided for in the following manner:

   a. The local LEA, where the child is residing, shall be the LEA for a child living in a foster home. The local LEA shall have primary responsibility for fulfilling the requirements of IDEA. *See Article 4, Section A.b. - LEA.*

   b. DCS shall refer the child to the LEA, where the child is residing, which will evaluate the child for IDEA eligibility. The local LEA shall convene an IEP Team meeting to determine IDEA eligibility and develop and implement an IEP if appropriate. *See Article 4, Section A.b. - LEA.*

   c. A DCS representative shall be present at the IEP Team meeting of a child who is IDEA eligible in DCS custody. However, the DCS representative may not sign the IEP, as a parent. The parent must sign the IEP. If a parent cannot be located, the LEA will appoint a surrogate parent. The surrogate parent, when representing the child's educational interests, shall have the same rights as parents of children who are IDEA eligible.

   d. DCS shall be financially responsible for the room and board of children in foster care.

4. The provision and cost of special education and related services for a child who is IDEA eligible in DCS custody and attending an approved DOE school at a DCS contract facility shall be provided for as follows:

   a. The DCS contract facility shall convene an IEP Team meeting in order to determine eligibility and develop and implement an appropriate IEP. The DCS contract facility provides special education and related services and ensures that a child who is IDEA eligible receives the services in his/her IEP in a reasonable time. The participation of other agencies in a child's IEP Team meeting and the financial responsibility to provide services shall not be altered because a child is attending school in a contract facility. The contract facility may receive reimbursement for services provided from other public agencies, as appropriate. *See Article 4, Section A.b.10 - LEA.*

b. Educational programs provided to children in DCS contract facilities shall be monitored by DOE. The Department of Finance and Administration shall monitor compliance with the contract provisions, and DCS shall provide the facility with technical assistance as necessary. Before entering into a contract with any facility that will provide educational programs to children in DCS custody, DCS will assure DOE that the facility will meet the standards enumerated in *Rules, Regulations and Minimum Standards for the Governance of Tennessee Public Schools* for non-public schools. DCS shall not contract with a facility for the provision of special education and related services for a child who is IDEA eligible in state custody who has DOE category five school approval.

c. The financial responsibility of other Participating Agencies to provide services in the child's IEP shall not be altered because the child who is IDEA eligible is being educated in a contract facility.

5. The provision and cost of special education and related services for a child with a disability in DCS custody, living in a contract facility that does not maintain an on-site school shall be provided for in the following manner:

a. The local LEA where the child is residing shall have primary responsibility for fulfilling the requirements of IDEA. *See Article 4, Section A.b. - LEA.*

b. DCS shall refer the child to the local LEA which will evaluate the child for IDEA eligibility. The local LEA shall convene an IEP Team meeting to determine eligibility and develop and implement an IEP if appropriate.

c. A DCS representative (which may include a DCS contract agency representative) shall be present at the IEP Team meeting of all children who are IDEA eligible in DCS custody. However, the DCS representative may not sign the IEP, as a parent. The parent must sign the IEP. If a parent cannot be located, the LEA will appoint a surrogate parent. The surrogate parent, when representing the child's educational interests, shall have the same rights as parents of IDEA eligible children.

6. The provision and cost of special education and related services for a child with a disability in DCS custody and living in a runaway house/shelter shall be provided for in the following manner:

a. Runaway houses/shelters have entered into a contract with DCS and are considered contract facilities with the same educational responsibilities as any other DCS contract facility. *See Article 4 Section C4.*

b. The runaway house/shelter shall convene an IEP Team meeting to determine eligibility and to develop and implement an IEP, if appropriate. The runaway house/shelter shall assume the costs of providing special education and related services as indicated in the IEP.

c. The financial responsibility of other Participating Agencies to provide services in the child's IEP shall not be altered because the child who is IDEA eligible is being educated in a runaway house/shelter.

7. The provision and cost of special education and related services for a child with a disability in DCS custody, living in a DCS residential facility and attending an in-house school shall be provided for in the following manner:

a. DCS may serve as the LEA for children who are in the custody of DCS and reside in DCS residential facilities. *TCA §37-5-119.* DCS, if it is the LEA, shall assume the cost of special education and related services for an IDEA eligible child who resides in a DCS residential facility.

b. In accordance with IDEA, DCS, as the LEA, shall convene an IEP Team meeting to determine eligibility and develop and implement an IEP in accordance with the child's Permanency Plan, if appropriate.

c. DCS, if it is the LEA, will pay for an evaluation to determine if a child in its custody and living in a residential facility may be IDEA eligible.

d. The financial responsibility of other Participating Agencies to provides services in the child's IEP will not be altered because the IDEA eligible child is being educated in a residential facility.

e. DCS shall pay the residential costs for children in DCS custody who need residential treatment.

8. The provision and cost of special education and related services for a child who is IDEA eligible in DCS custody, residing in a Youth Development Center (YDC) shall be paid for in the following manner:

a. DCS shall serve as the LEA for children who are in the custody of DCS and reside in YDC. *TCA §37-5-119.* DCS shall assume the cost of special education and related services for a child who is IDEA eligible who resides in a YDC.

b. In accordance with IDEA, DCS, as the LEA, shall convene an IEP Team meeting to determine eligibility and develop and implement an IEP in accordance with the child's Permanency Plan, if appropriate.

c. DCS will pay for an evaluation to determine if a child in its custody and living in a YDC may be IDEA eligible.

d. The financial responsibility of other Participating Agencies to provides services in the child's IEP will not be altered because the child who is IDEA eligible is being educated in a YDC except that the child is not eligible for TennCare. *But see Article 4 Section C14.*

e. DCS shall pay the residential costs for children in DCS custody who need residential treatment.

9. The provision and cost of special education and related services for a child with a disability in DCS custody and living in a detention center shall be provided for in the following manner:

a. The local LEA where the detention center is located shall serve as the LEA for a child who is IDEA eligible living there.

b. The local LEA shall convene an IEP Team meeting to determine eligibility and develop an IEP for a child who is IDEA eligible, if appropriate. The local LEA shall provide the detention center with teachers who shall provide the educational program to the child with a

disability in the detention center in accordance with the child's IEP. The LEA shall assume the financial responsibility for the provision of special education and related services.

c. The financial responsibility of other Participating Agencies to provide services in the child's IEP shall not be altered because the IDEA eligible child is being educated in a detention center.

10. The obligation to make FAPE available to all children with disabilities does not apply to students age eighteen (18) to twenty-one (21) if, prior to incarceration in an adult correctional facility, the students were not actually identified as being IDEA eligible and did not have an IEP. If a child with a disability is convicted as an adult under state law and incarcerated in an adult prison, the following requirements of IDEA do not apply: 1) the requirements contained in 34 CFR §300.138 and §300.347(a)(5)(i) (relating to participation of children with disabilities in general assessments; and 2) the requirements of §300.347(b) (relating to transition planning and transition services) with respect to students whose eligibility under Part B will end because of their age before they will be eligible to be released from prison considering their sentence and possibility for early release. The IEP Team of a student with a disability who is convicted as an adult and incarcerated in an adult prison may modify the student's IEP or placement if the state has demonstrated a bona fide security or compelling penological interest that cannot otherwise be accommodated. The IDEA requirements relating to the least restrictive environment do not apply to the modification of placement for penological reasons. *34 CFR §300.311.*

11. In order to expedite the provision of special education and related services to any child who is IDEA eligible in DCS custody, a LEA formerly serving the child shall provide DCS with the child's education records within fourteen (14) calendar days of receipt of the request unless there is a critical need to expedite forwarding of the records. The former LEA providing the child's special education and related services should forward to DCS the child's IEP and all evaluations which were used to assess the child's IDEA eligibility. However, failure to receive education records does not suspend the responsibility of DCS to provide a child with a disability FAPE in the least restrictive environment. Nothing in this provision is meant to supersede the requirements of FERPA, state and federal law and the regulations promulgated thereunder.

12. When it appears that a child who is IDEA eligible in DCS custody can be provided FAPE in a less restrictive environment, DCS shall facilitate the child's transition to the LEA in the following manner:

a. DCS shall notify the LEA of the need to convene an IEP Team meeting. DCS and the LEA will work together to determine an appropriate placement. A representative from DCS shall attend an IEP Team meeting to assist in determining the most appropriate educational placement. However, the DCS representative shall not sign the IEP as parent.

b. If the IEP Team determines that the child should be provided FAPE in the LEA, as the least restrictive environment, the child shall be enrolled in the local LEA where the child is residing. The LEA shall be responsible for providing and paying for special education and related services for the IDEA eligible child not DCS. Absence of a representative from DCS or the local LEA at the IEP Team meeting does not relieve that agency from any responsibilities imposed by this section.

13. When a child who is IDEA eligible is discharged from DCS custody, DCS will notify DOE/Division of Special Education of release information and identify the LEA where the student will be attending school. When a child in DCS custody transitions into the local LEA,

DCS will provide the local LEA with the education records of the child consistent with IDEA and FERPA. The schools in the facility or contract agency shall provide the LEA with the education records of children who are IDEA eligible transitioning to the LEA within fourteen (14) calendar days of receipt of the request from the LEA unless there is a critical need to expedite forwarding of the records. However, failure to receive education records does not suspend the responsibility of the LEA to provide FAPE. Nothing in this provision is meant to supersede the requirements of the FERPA, state and federal law and the regulations promulgated thereunder.

14. Medical services for children in DCS custody shall be paid for as follows:

a. TennCare is responsible for the provision of all covered medically necessary services to children in DCS custody who are TennCare enrollees except children who are inmates as defined in Tenn.Rule 1200-13-12-.01(25). Medical and behavioral services are provided by the assigned MCO or BHO. However, DCS provides case management services and residential treatment services to children in DCS custody.

b. DCS, when acting as a LEA for a child in DCS custody, will pay for medical services specified in the child's IEP that for the purposes of TennCare are not covered medically necessary services.

c. Children who are inmates, as defined in Tenn. Rule 1200-13-12-.01(25), are not eligible for TennCare. Therefore, DCS shall contract with appropriate providers, in addition to an on-site nursing staff, to ensure that the necessary medical and mental health services are provided to children who are inmates.

15. As mandated by IDEA, federal and state law and regulations, DOE will monitor all special education programs and services in all DCS facilities and contract agencies using appropriate monitoring procedures. DOE will assist DCS in providing technical assistance and in-service training to DCS staff, caseworkers, and contract facility administration and teachers in identified areas of need relating to children with disabilities. DCS shall work with contract facility staff and faculty in identifying training needs. DOE, through its monitoring efforts, shall also assess areas needing improvement and coordinate technical assistance through DCS. As a LEA, DCS shall be responsible for submitting a corrective action plan (CAP) to respond to any areas of deficiencies identified by DOE through its monitoring and/or compliance efforts. *See Article 4 Section A.*

16. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, termination, delay, suspension, or reduction of TennCare services for a child in DCS custody. *TennRule 1200-13-12-.11, see also Grier revised Consent Decree.* Children in DCS custody receiving enhanced behavioral health services provided by DCS may appeal to the Solutions Unit. In addition to the medical and enhanced behavioral health procedures, DCS has developed policies and procedures to resolve complaints and grievances in a timely manner.

D. Tennessee Department of Mental Health and Developmental Disabilities

1. No eligible child shall be denied special education and related services in the least restrictive environment due to his/her status as a child residing in a Regional Mental Health Institute

(RMHI). Placement in a RMHI may not be solely an educational placement but must meet the requirements of one of the applicable state statutes governing psychiatric hospitalization. A child must be admitted by a physician pursuant to state statutes (TCA §§33-6-101, 33-6-103-104, 33-3-401, 33-3-412, and 37-1-128). Except in circumstances of an emergency, as defined in TCA §33-6-103 and §33-3-412, admission to a RMHI is subject to the availability of suitable accommodations. TDMHDD will provide care for all children who are residing in a RMHI, as provided in state and federal law. All educational placements must remain with the child's IEP Team.

2. TDMHDD will assume the costs of special education and related services for all children who are IDEA eligible in a RMHI through state appropriations if the child meets the statutory requirements for hospitalization pursuant to state statutes (TCA §§33-6-101, 33-6-103-104, 33-3-401, 33-3-412, and 37-1-128). Special education and related services shall be provided through TDMHDD schools at the RMHI. TDMHDD schools operate under 34 CFR §300.2 as "other State agencies and schools" and as such, must meet the *Rules, Regulations, and Minimum Standards for the Governance of Tennessee Public Schools* established by DOE. *See Article 4 Section A.*.

3. As mandated by federal and state law and regulation, DOE will monitor all IDEA programs and services provided by RMHI using an appropriate monitoring instrument. *See Article 4 Section A.*. DOE, in conjunction with TDMHDD, shall provide technical assistance regarding IDEA requirements and special education and related services to RMHI staff and teachers, as appropriate. DOE through its monitoring, in conjunction with TDMHDD and the RMHI staff, shall identify training and technical assistance needs at the RMHIs.

4. When a child who is IDEA eligible resides in a RMHI and is receiving inpatient services, the RMHI school will continue to follow the child's IEP from the previous educational placement until the child is discharged. However, the child's IEP shall be reviewed and modified as appropriate and consistently with IDEA. If the child who is IDEA eligible is residing in the RMHI and does not have an IEP, the RMHI school shall convene an IEP Team meeting in order to determine IDEA eligibility and develop an IEP if appropriate.

5. In order to expedite the provision of special education and related services to any child who is IDEA eligible living in a RMHI, the LEA formerly serving the child shall provide the RMHI with the child's education records within fourteen (14) calendar days of receipt of the request unless there is a critical need to expedite forwarding the records. With the consent of the child's parent, TDMHDD will notify the local LEA that an IDEA eligible child is being released from a RMHI and will be returning to the local LEA. The RMHI shall provide, within fourteen (14) calendar days of receipt of request, the education records of children educated at the RMHI who return to the LEA, to a DCS residential facility school, or a contract facility school where the child will be attending school unless there is a critical need to expedite forwarding the records. However, failure to receive such records does not suspend the responsibility of TDMHDD, DCS, or the LEA to provide or cause to be provided special education and related services to a child who is IDEA eligible. The transfer of records will be consistent with IDEA, FERPA, and all other applicable state and federal regulations.

6. When it appears that a child who is IDEA eligible and is receiving care in a RMHI can be provided an appropriate educational program in a less restrictive environment, a representative from the LEA serving the geographical area where the RMHI is located shall be invited by the RMHI to attend an IEP Team meeting to determine the most appropriate educational placement. If the IEP Team determines that the child can be provided FAPE in a less

restrictive environment, the child will be enrolled in the LEA where the RMHI is located. The LEA serving the geographic area where the RMHI is located shall be responsible for providing special education and related services under IDEA. Upon enrollment, the financial responsibility for the child's IDEA services shall transfer from TDMHDD to the LEA where the child attends school. All other costs shall be paid in accordance with TCA §33-4 (Mentally Ill and Mentally Retarded Persons - Cost of Services).

7. TDMHDD shall have no responsibility for the costs of special education and related services under IDEA for a child prior to admission to a RMHI, or when a child who is IDEA eligible has been discharged from a RMHI.

8. Nothing in this Agreement is meant to alter or abrogate any contractual agreement between TDMHDD and other parties or agencies regarding the provision of inpatient hospitalization.

9. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, delay, termination, suspension or reduction of mental health services for a child who is receiving mental health services in a RMHI. *TennRule 1200-13-12-.11, Grier revised Consent Decree.*

E. Tennessee Division of Mental Retardation Services

1. The Division of Mental Retardation Services (DMRS) provides services for children with mental retardation through the Home and Community Based Services (HCBS) waiver and state funded services. It does not provide special education or related services as described in IDEA Part B. Access into the waiver is not guaranteed and is subject to funds available through state appropriations. Services funded by state appropriations are provided to those who are eligible in proportion to the availability of funds. DMRS programs are not an entitlement.

2. If a child who is IDEA eligible is residing in one of the DMRS Developmental Centers, the local LEA will ensure that the child receives FAPE in the least restrictive environment. The local LEA will convene an IEP Team meeting to determine eligibility, and develop and implement an appropriate IEP in accordance with IDEA and all applicable state and federal regulations. The local LEA is responsible for the cost and provision of special education and related services. Medicaid pays residential costs for children residing in developmental centers through ICF/MR (Intermediate Care Facility for the Mentally Retarded) funds.

3. For children served in the HCBS waiver, the LEA where the child is residing will provide special education and related services if the child is IDEA eligible. While there are no age requirements associated with the HCBS waiver, a person shall be twenty-two (22) years of age or have a high school diploma and no longer eligible to receive services under IDEA to qualify for day habilitation or supported employment services.

4. Everyone in the HCBS waiver shall have an Independent Support Coordinator (ISC). The ISC or case manager shall attend the IEP Team meeting of a child who is IDEA eligible. At the IEP Team meeting, the ISC will work with the other team members to assure that the Individual Support Plan (ISP) and the IEP complement each other so that the child is provided with a comprehensive and effective set of services and supports. DMRS, in collaboration with DOE, will provide technical assistance to parents, case managers, and ISCs regarding the IEP development process.

5. As part of the IEP Team process, the LEA should notify DMRS when it believes a child is eligible and may benefit from DMRS services and supports. Consistent with IDEA, the LEA shall be responsible for inviting a DMRS representative to a child's IEP Team meeting when the child reaches age 14, to facilitate planning for the child's transition from school services to adult services. These DMRS or HCBS waiver funded services for which a child who is IDEA eligible qualifies should be stated in the child's ITP at age 16. The IEP/ITP will be updated annually. *See Article 4 Section A.b. - LEA.*

6. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, delay, termination, suspension or reduction of waiver services. *TennRule 1200-13-12-.11, Grier revised Consent Decree.*

F. Tennessee Department of Human Services

Division of Rehabilitation Services

1. The Department of Human Services, Division of Rehabilitation Services (DHS/DRS) will provide vocational rehabilitation services for individuals with disabilities who meet DHS/DRS's eligibility criteria. DHS/DRS is not an entitlement program. Services funded by state appropriations, matched with federal funds are provided to those who are eligible in proportion to the availability of funds.

2. An individual with a disability may be self-referred to DHS/DRS, or may be referred by another individual or another agency. A referral may be made by contacting a rehabilitation services office in person, by mail, or by telephone.

3. An individual is eligible for assistance if he is an individual with a disability and requires vocational rehabilitation services to prepare for, secure, retain, or regain employment. *34 CFR §361.42(a).* For DHS/DRS purposes, an individual with a disability means any individual who: 1) has a physical or mental impairment that constitutes or results in a substantial impediment to employment for that individual; and 2) can benefit in terms of an employment outcome from vocational rehabilitation services. *Id.* The determination of eligibility for vocational rehabilitation services shall be based on existing and current information from other programs and providers, the individual and his family. To the extent that such data is unavailable or insufficient for determining eligibility, DHS/DRS shall secure the necessary evaluations to make a determination.

4. Eligibility determinations will be made by DHS/DRS counselor. Determinations made by officials of other agencies, particularly education officials, regarding whether an individual has a qualifying disability, shall be used, to the extent appropriate and consistent with the requirements of the Rehabilitation Act of 1973 as amended (29 USC §720 *et seq.*), in assisting DHS/DRS in making such determinations. *34 CFR §361.42(c)(1)(2).*

5. To the extent possible, DHS/DRS will make available a vocational rehabilitation counselor to participate in the IEP Team meeting when requested by the LEA. The rehabilitation counselor will assist in the formulation of an IEP/ITP and secure a copy of the IEP/ITP for the student's DHS/DRS case record if the student is eligible for vocational rehabilitation services. The vocational rehabilitation counselor will establish and maintain a working relationship with

special education supervisors, vocational education supervisors, directors, secondary school guidance counselors and staff of DMRS and TDMHDD.

6. Twelve to eighteen months prior to the student's exit from school, the LEA will provide DHS/DRS the most current copies of medical, psychological, vocational, and social evaluations and all other available information needed for establishing eligibility and identifying vocational rehabilitation needs of each student referred for services. If the information is not appropriate, DHS/DRS may need to secure current information to provide a basis for an eligibility determination.

7. When DHS/DRS determines a student with a disability will be eligible for vocational rehabilitation services, the student, and the student's parent/guardian if appropriate, will develop an Individualized Plan for Employment (IPE), with the assistance of a Vocational Rehabilitation Counselor or other technical assistance as required. The IPE will include the specific employment outcome chosen by the student, consistent with the student's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice, in an integrated setting to the maximum extent appropriate. It will include a description of vocational rehabilitation services to be provided by DHS/DRS, timelines for initiation of services and achievement of the employment outcome. Also included are the vendors and method of procuring services, criteria to evaluate progress, and the terms and conditions of the IPE. If applicable, information about any projected need for rehabilitation technology, personal care assistance, supported employment, or post-employment services will be included.

8. DHS/DRS begins to help coordinate transition services to high school students with disabilities, who meet DHS/DRS eligibility criteria, 12-18 months prior to their exit from school to assist them in gaining employment. Transition services are provided jointly by DHS/DRS through Vocational Rehabilitation Counselors. A Vocational Rehabilitation Counselor will assist in coordinating services including vocational evaluation, training, placement, and other services either directly, or through referral to appropriate agencies. The types of services provided are based on the needs of the individual. DHS/DRS will coordinate and/or provide vocational rehabilitation post-secondary training and job placement, and participate in public and professional awareness activities regarding availability of services.

9. DHS/DRS will provide vocational rehabilitation services to an eligible individual. These services include any services listed in an IPE necessary to assist an individual with a disability in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual. DHS/DRS will coordinate assessment activities and program planning. Any services provided by DHS/DRS are available only to the extent that they relate to an employment outcome.

10. DHS/DRS is not an entitlement program and provides services to eligible individuals to the extent funding will allow. Some services are based on an economic need standard that takes into account the number of family members living in the home and available family financial resources. Services which may be provided regardless of financial need include: diagnostic exams, counseling and guidance, maintenance and/or transportation necessary to determine eligibility; job placement, including required union and organizational dues; tuition for post-secondary schools and training; personal/work adjustment; supported employment; tutorial training; orientation and mobility training services; reader, interpreter, translator, attendant or job coaching services; licenses or permits for an occupation or business; and services provided

by the Tennessee Rehabilitation Center. Other services available are provided in proportion to the financial resources of the student/family.

11. DHS/DRS is required by State laws and regulations TCA § 71-1-104 and 71-1-105; TCA § 49-11-601 and by Federal law and regulations (29 U.S.C. §721(a)(5)(A) as amended and 34 C.F.R. §361.36) to maintain an order of selection when providing services to persons meeting the basic guidelines for eligibility. Vocational Rehabilitation's order of selection is designed to ensure that persons with the most significant disabilities receive a higher priority for services. Based on prior experience, as well as budgetary expectations, DRS anticipates continuing to be able to serve all eligible individuals who apply for services. The order of selection represents contingency planning which will allow the division to quickly implement services to only priority groups should necessity arise due to funding limitations.

12. When an applicant for vocational rehabilitation services or an individual being provided vocational rehabilitation services is dissatisfied with any action concerning the furnishing or denial of these services, the individual or his representative may file a request for an informal administrative review, mediation, or fair hearing at the nearest vocational rehabilitation office within ten (10) working days of their disagreement or unfavorable treatment by DHS/DRS. *T.C.A. §49-11-612.* A Client Assistance Program is available to provide assistance in informing and advising all applicants for services of available benefits under the Rehabilitation Act. Upon request the Client Assistance Program may assist each individual in his/her pursuit of services provided under the Rehabilitation Act, including assistance in pursuing legal, administrative, or other appropriate remedies to ensure the protection of rights under this Act.

Article Five

IDEA Part C Services

Early Intervention System

The mandate of IDEA Part C is to develop a comprehensive, interagency, multidisciplinary, family-centered and community based services system that is accessible to all infants and toddlers birth to age three with disabilities and their families. The purpose of this Interagency Agreement is to specify the financial responsibility of each Participating Agency and establish procedures for achieving timely resolution of intra-agency and interagency disputes. *34 CFR §303.523.*

A. Collaboration

1. Each Participating Agency shall support the ongoing development and implementation of Tennessee's statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for all infants and toddlers with disabilities and their families. Each Participating Agency shall support and assist the coordination of payments for these early intervention services from all public and private sources to enhance the State's capacity to provide quality early intervention services and to expand and improve existing services. *34 CFR §303.01.*

2. The Commissioner of each Participating Agency that is involved in the provision of or payment for early intervention services shall appoint a representative with sufficient authority to engage

in policy planning and implementation on behalf of their Agency to serve on the ICC. *34 CFR §303.600 et seq.*

3. Each Participating Agency agrees to support the ongoing development of policies and procedures which will ensure that all infants and toddlers with disabilities and their families have timely and efficient access to appropriate service coordination, evaluations, referrals, services, transition planning, and implementation. Each Participating Agency shall promote and support the implementation of such policies and procedures within their agency and contract providers to ensure compliance with federal statutes and regulations regarding infants and toddlers with disabilities.

4. Each Participating Agency shall conduct individual or coordinated efforts to provide information to the public regarding Tennessee's system of early intervention services to include information on accessing the service system. *34 CFR §303.320.* Each agency, on the state and local level, shall submit and annually update information to be included in Tennessee's Central Directory of services and will, as appropriate, assist in the distribution of this Directory. *34 CFR §303.301.*

5. Each Participating Agency shall provide training and technical assistance to its service providers and, to the greatest degree appropriate, the staff of other Participating Agencies, regarding their roles and responsibilities in the provision of early intervention services in accordance with IDEA Part C.

6. Each Participating Agency shall appoint a representative, with the capacity to speak on behalf of the Participating Agency, to participate in Local Interagency Coordination Councils to facilitate collaboration in the planning, coordination, and provision of early intervention services at the local level. Each Participating Agency shall also encourage its local providers to participate in Local Interagency Coordination Councils.

7. Each Participating Agency shall ensure that its service coordinators, as appropriate, on the local level provide information regarding parental rights and procedural safeguards under IDEA to families of infants and toddlers who are IDEA Part C eligible and are being served by their agency.

8. Each Participating Agency shall ensure that its services providers, as appropriate, submit data to the lead agency (DOE) on an annual basis to fulfill the requirements of IDEA and its accompanying Federal Regulations for submission of the December 1 Child Count to the U.S. Department of Education/Office of Special Education Programs.

9. Each Participating Agency, pursuant to individual agreements with the lead agency, shall assist the lead agency (DOE) in facilitating the monitoring of early intervention programs and services to ensure quality and compliance with IDEA and federal and state regulations for services provided to infants, toddlers, and families that are Part C eligible. *34 CFR §303.501(a).* Each Participating Agency shall incorporate IDEA Part C standards into their monitoring process to ensure that their programs, providers, and contract agencies are in compliance with IDEA. DOE, as lead agency, shall receive a copy of each Participating Agency's monitoring instrument and monitor its format to ensure compliance. DOE shall maintain the option to go on-site with each Participating Agency's monitoring team or to review the agency's monitoring report to fulfill DOE's early intervention system monitoring obligations under IDEA Part C. DOE also has the discretion to follow up with the programs,

providers, and contract agencies to ensure the correction of any deficiencies and enforce the requirements of IDEA. *34 CFR §303.501(b).*

B. Referral and Intake

1. Each Participating Agency shall contribute to the development and implementation of a unified system of developmental screening and referral for infants and toddlers birth to three. In order to facilitate referrals and developmental screenings, each Participating Agency shall provide, as appropriate, training and technical assistance to primary referral sources (hospitals-including prenatal and post-natal care facilities, physicians, parents, child care programs, LEAs, public health facilities, and other health care and social service providers) who are required to refer any infant or toddler they suspect is experiencing developmental delay(s) to their local TEIS Point of Entry within two (2) business days after examining or observing the infant or toddler. *34 CFR §303.321.*

2. DOE, in conjunction with TEIS, shall develop and disseminate Part C evaluation procedures and requirements to the Participating Agencies and potential providers and evaluators. DOE/TEIS will train or provide training to evaluators and providers to use the state's eligibility criteria, as outlined in the State's Early Intervention Plan. DOE/TEIS shall also implement uniform procedures for documenting results of the evaluations and assessments for the IFSP Team. Supervision and monitoring activities conducted by DOE/TEIS will ensure timely evaluations and assessments of potentially eligible infants and toddlers.

3. When a Participating Agency finds, suspects, or receives a referral from a primary referral source, the Participating Agency or their agent shall forward that referral immediately to the local TEIS Point of Entry or assign a Service Coordinator to begin a multidisciplinary evaluation process to determine the infant or toddler's eligibility. The multidisciplinary evaluation process must include a minimum of two (2) disciplines. If the agency does not have the capacity to fulfill the responsibility of service coordination and/or arranging for an appropriate eligibility evaluation, that agency will immediately refer the infant or toddler and family to their local district office of TEIS. In every instance, the receiving agency will notify the TEIS district office of all infants and toddlers who are or potentially are Part C eligible.

4. The Service Coordinator will access the evaluation(s) needed for each infant or toddler through the appropriate Participating Agencies as required in IDEA Part C. Each Participating Agency will work collaboratively to ensure the availability of providers to evaluate each infant or toddler suspected to be in need of early intervention services utilizing the state's eligibility criteria promulgated in the Early Intervention State Plan. The providers will evaluate the infant or toddler in all developmental areas, such as adaptive skills, physical (including vision and hearing) development, communication skills, social/emotional development, and cognition. The multidisciplinary evaluation process must be completed and an IFSP developed within forty-five (45) calendar days from the date of receipt of the referral by the primary referral source if the infant or toddler is found to be IDEA eligible. *34 CFR §303.321(e).* Early intervention services and evaluations must be provided within a reasonable time period. Therefore, in order to ensure that evaluations and early intervention services are provided in a timely and efficient manner, DOE/TEIS may contract with appropriate providers or provide the needed evaluations and/or services itself pending reimbursement from the agency that has ultimate responsible for the payment or in accordance with the payor of last resort

requirements. *34 CFR §303.527(b).* In order to receive reimbursement from TennCare, the service provider must be a TennCare provider.

C. Provision of Services

1. Early intervention services must be provided in collaboration with parents to meet the developmental needs of the infant or toddler. Qualified personnel, under public supervision, and in accordance with a current IFSP shall provide these services. Early intervention services shall be provided at no cost to parents unless a system of sliding fees has been implemented by the Participating Agency or the Lead Agency (DOE). *34 CFR §303.521.* The use of private insurance must be voluntary and consented to in writing by the parents. This written consent shall be obtained by a representative of the local TEIS Point of Entry. If a parent consents to access private insurance for early intervention services, Part C funds may be used to pay the family's copayment assessed by the insurance company. Each Participating Agency shall promote the provision of early intervention services to infants and toddlers to the greatest extent appropriate, in natural environments, including the home and community settings in which infants and toddlers without disabilities participate. *34 CFR §303.12 (a),(b).*

2. Once an infant or toddler has been determined to be eligible for early intervention services, the IFSP Team will meet to develop a comprehensive plan of early intervention services. The IFSP Team will include the service coordinator, the infant or toddler's parents and other family members, as requested by the parent, an advocate or person outside the family, if the parent requests his/her participation, person(s) directly involved in conducting the evaluations and assessments, and persons from the Participating Agencies who will be providing services to the infant, toddler or family, as appropriate. *34 CFR §303.343.* The IFSP team will, with concurrence of the family, designate a Service Coordinator. The Service Coordinator may be the service coordinator who was initially assigned to the infant or toddler during the evaluation process or it may be someone different. The Service Coordinator shall be from the agency most relevant to the needs of the infant or toddler and family to ensure the implementation of the IFSP in compliance with IDEA Part C. *34 CFR §303.344(g).* The Service Coordinator shall be responsible for coordinating any additional evaluations and assessments, as necessary; facilitating the IFSP meeting and development of the IFSP; coordinating with medical and health providers; and coordinating and monitoring the delivery of the services indicated in the IFSP.

3. DOE, with the assistance of the other Participating Agencies, shall provide training and technical assistance to Service Coordinators to assist them in performing the requirements of service coordination particularly facilitating the interaction between families and service providers. DOE will establish a technical assistance system to support service coordinators and service providers. DOE is also responsible for monitoring service coordination.

4. In the IFSP, the payor and the provider of each service will be designated as well as the frequency, intensity, and method of delivering each service. *34 CFR §303.340.* Services will be delivered in a family-centered manner. This includes allowing and encouraging full participation of the family in the planning and implementation of early intervention services and to the greatest extent appropriate, providing services in natural environments and in a manner which incorporates those services into the family's normal lifestyle and routines.

5. Early intervention services, as defined in IDEA Part C and this Agreement, shall be available to infants and toddlers who are IDEA eligible as determined appropriate by the IFSP Team. In addition to meeting the eligibility requirements of IDEA, an infant or toddler must also meet the eligibility requirements of the individual agencies to receive services from that agency.

6. The Service Coordinator shall ensure that transition planning begins no later than the toddler's second birthday. With parental consent, the service coordinator shall refer the toddler to the LEA at age two (2) and arrange for a transition conference no later than ninety (90) days prior to the toddler's third birthday. *34 CFR §303.344(h).* For toddlers who are located and determined to be eligible for early intervention services through TEIS after the age of two (2), a written transition plan shall be included in the initial IFSP. Families will be included in all aspects of transition planning. When a toddler turns age three (3), an IEP must have been developed. In lieu of an IEP, an IFSP, developed in accordance with Part C with appropriate modifications to meet Part B requirements, may be used with the concurrence of the parent. In either case, the IEP or IFSP must be developed by the toddler's third birthday.

7. Each Participating Agency shall support the interdepartmental exchange of information as appropriate and in accordance with IDEA, and all other federal and state laws and regulations regarding confidentiality. DOE has developed an authorization form for the procurement and/or release of a infant or toddler's confidential records to assist in the effective provision of early intervention services. The designated Service Coordinator will ensure that informed consent is obtained from the family before any information is shared. The family may revoke the consent at any time. All information will be released to the family's designated Service Coordinator who shall compile and maintain a complete service file for the child and family. *See Attachment 4 - Early Intervention Release Form.*

D. Tennessee Department of Education

1. DOE has been designated by the Governor as Lead Agency for the State's Early Intervention System mandated by IDEA. *34 CFR §303.500.* Therefore, DOE shall pursue collaborative strategies with all other Participating Agencies that are part of the early intervention system. DOE, as lead agency, shall:

   a. Promulgate standards for early intervention service provision;
   b. Ensure that IDEA Part C funds are not used to replace or supplant any activities required under any other State and Federal program. *34 CFR §303.527(a);*
   c. Provide technical assistance to Participating Agencies, service providers, and contract agencies that provide early intervention services to ensure compliance with the provisions of IDEA Part C. *34 CFR §303.501 (b)(3);*
   d. Monitor all early intervention programs and services provided to infants and toddlers and their families that are Part C eligible whether or not they are supported by IDEA Part C funds. *34 CFR §303.501 (b)(1);* and
   e. Ensure that disputes regarding payment or provision of services are resolved in a timely manner.

2. In addition to its responsibilities as lead agency, DOE shall provide and pay for early intervention services documented on the family's IFSP for which there is no other responsible payor. DOE's responsibility will be limited to the services specified under IDEA. Part C funds

will not be utilized for payment for any service which is considered experimental in nature. *34 CFR §303.527.*

3. When a family consents to accessing its private insurance for early intervention services, DOE will utilize Part C funds to cover deductibles and copayments to ensure that the services are provided at no cost to the family unless DOE establishes a system of sliding fees. If a TennCare enrollee is assessed a copayment, the LEA may pay that copayment. DOE funds cannot be used to supplement payment for services covered by any other program supported by federal, state, or local funds. *34 CFR §303.527 (a)*

4. When a family declines the use of private insurance for early intervention services indicated on the IFSP for which there is no other responsible payor, DOE will secure the service(s), via the local TEIS office, from a provider who has agreed to provide the service in a manner and cost rate established by DOE. DOE shall assume the costs of these services only if it is in accordance with the payor of last resort provisions of IDEA Part C and appropriately documented in a current IFSP. *34 CFR §303.527(a).*

E. Tennessee Department of Health

1. Department of Health (DOH) programs that may have infants or toddlers in need of early intervention services include the Maternal and Child Health (MCH) Title V programs of Children's Special Services (CSS), Healthy Start, HUG, WIC, and child health EPSDT services. Other DOH programs include Traumatic Brain Injury, Hemophilia, Ryan White, and Renal. DOH services are not an entitlement program.

2. DOH ensures that department personnel in child health programs shall be trained to make appropriate referrals for infants and toddlers potentially in need of early intervention related services. DOH shall also provide enrolled families and staff with information regarding Child Find, early intervention services and the IFSP process.

3. DOH programs, that provide services to infants and toddlers birth to 3 years of age identified with a developmental delay and IDEA Part C eligible, will appropriately document the type and amount of service and/or reimbursement provided for the infant, toddler or family as determined by the IFSP. The DOH program representative or authorized representative shall participate on the IFSP team to assist in the process to determine the amount and type of service to be provided or reimbursed by the DOH program and to assist in the process to determine the lead service coordinator. All services provided or reimbursed must meet the CSS program rules and regulations, scope of service and policy.

4. Payment for an early intervention service which is determined necessary by the IFSP team that is appropriately documented on the family's IFSP, and is a service for which a child and family are eligible under MCH or any other DOH programs will be the financial responsibility of DOH.

5. CSS provides reimbursement for medical services for infants or toddlers who meet financial and diagnostic eligibility guidelines. CSS may provide services that have been denied by, or are not covered by, other third party payors but that are considered to be "medically necessary" by the CSS program and the child's provider. Care Coordination services are provided to children who meet the diagnostic eligibility guidelines and may be limited by CSS funding or

staff availability. The CSS program does not provide early intervention services other than those related to medical treatment, audiological assessment, physical therapy, occupational therapy, speech-language therapy, therapies, limited DME, and medications. CSS is not an entitlement program.

F. Bureau of TennCare

1. TennCare contracts with MCOs to provide medical care through networks of subcontracted health providers. MCOs are paired with BHOs to create access to a network of providers for enrollees in need of mental health and substance abuse services. TennCare monitors MCOs and BHOs to ensure that they are in compliance with TennCare Rules and are providing accessible in-network providers to TennCare enrollees.

2. TennCare shall perform TennCare eligibility determinations for children who apply for TennCare and conduct EPSDT outreach to help TennCare enrollees receive medically necessary care consistent with *John B.* Consent Decree at pp. 15-18.

3. TennCare is responsible for providing EPSDT services for all children who are TennCare enrollees. EPSDT services include: (a) periodic well-child screenings in accordance with the recommendations of the American Academy of Pediatrics; (b) medically necessary health and behavioral health diagnostic services; and (c) medically necessary health and behavioral health treatment services. EPSDT treatment services include "such other necessary health care, diagnostic services, treatment and other measures [described in §1396d(a)] . . . to correct or to ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan." *42 USC §1396d(r)(5); John B. Consent Decree at p. 5.* EPSDT services are based on the individual child's medical, developmental, and behavioral health needs. No prior authorization by the MCO is needed for a screen conducted by a PCP, and the MCO will provide all medically necessary covered services regardless of whether or not the need for such services was identified by a provider who received prior authorization or by an in-network provider. *John B. Consent Decree at p. 21.* TennCare (including its contractors, the MCOs and BHOs) cannot impose limitations on EPSDT services other than medical necessity. This means that the state cannot set arbitrary limits of duration, scope, or cost of services under EPSDT. *John B. Consent Decree at p. 33.* The MCOs and BHOs have the discretion to require that their network providers deliver TennCare covered services, as long as the networks are sufficient in size and scope to meet the access standards of the MCO/BHO's contract with the state.

4. Any encounter with a health professional practicing within the scope of his/her practice is an interperiodic screen. Any person such as an educator, parent, or health professional who suspects a health problem may refer a child for an interperiodic screen. An interperiodic screen does not have to include any screening elements required for a periodic screen. No prior MCO authorization is required for an interperiodic screen, and the MCO shall provide all medically necessary covered services identified by the interperiodic screen. *John B. Consent Decree at p. 23.*

5. The child's MCO will be responsible for identifying whether or not the child's EPSDT screenings are up-to-date and shall be responsible for providing screenings as needed. These screens shall be provided by the child's PCP under contract with the MCO. When it is suspected that a TennCare enrolled child may have a particular medical or behavioral health

problem and the child is up-to-date on his EPSDT screenings, the child should be referred to the child's PCP for an EPSDT interperiodic screen. The PCP will make recommendations to the MCO/BHO if he/she believes there is a need for additional diagnosis and/or treatment that is medically necessary. *John B. Consent Decree at p. 38.*

6. TennCare will provide all covered medically necessary services, including durable medical equipment, for all children who are TennCare enrollees, regardless of whether or not these children are IDEA eligible. TennCare shall provide transportation to and from appointments for services covered by TennCare when the enrollee does not have access to transportation services. *John B. Consent Decree at pp. 41-2.* TennCare may not disqualify an eligible service for TennCare reimbursement because that service is provided in accord with an IFSP. *34 CFR §303.527(c).* MCOs and BHOs have the discretion to require that covered services be delivered by providers in their networks, within the access standards required in their contracts with the state.

7. Emergency medical services are available twenty-four (24) hours per day, seven (7) days per week for TennCare enrollees. Coverage of emergency medical services is not subject to prior authorization by the MCO. *Tenn.Rule 1200-13-12-.04(4)*

8. Each TennCare MCO and BHO is responsible for the management of medical care and continuity of care for all its TennCare enrollees including children who are IDEA eligible. Specific responsibilities include performance of reasonable preventive health case management services, appropriate referral and scheduling assistance for enrollees needing specialty health care services, monitoring of enrollees with ongoing medical conditions, coordinated hospital and/or institutional discharge planning that includes post-discharge care as appropriate, maintenance of an internal tracking system which identifies the current preventive service screening status and pending due dates for each enrollee, and authorization of out-of -plan or out-of-state services which are medically necessary due to an emergency. *Contractor's Risk Agreement between TennCare and MCO September, 1995.* In addition, to coordinate EPSDT screens and services, each TennCare MCO/BHO shall provide case management services by assisting children for whom case management is medically necessary. *John B. Consent Decree at p. 38.* The case management provided shall center on the process of collecting information on the health needs of the child, making and following up on referrals as necessary, and activating the examination/diagnosis/treatment loop. *Id. at pp. 38-9.* The case management services must meet the needs of the child and cannot be used exclusively as a tool for prior authorization. *Id. at p. 39.*

9. TennCare shall coordinate the delivery of covered health and behavioral health services with services offered by other state health agencies and shall attempt to make use of other public health, mental health, and educational programs and related programs such as Head Start to ensure an effective child health program. MCOs are responsible for requesting the IFSPs of enrollees who they know are children who are IDEA eligible and enrolled in each MCO. TennCare has developed a release form to provide to TEIS that a parent may use to consent to the release of education records consistent with IDEA, FERPA and all applicable state and federal regulations. TEIS or the designated service coordinator is responsible for sharing the IFSP with the PCP after obtaining appropriate parental consent. *See Attachment 3 - TennCare Release Form.* MCOs shall accept the IFSP indication of a medical problem or shall have the child appropriately tested. Coordination by the MCO and service coordinator should be calculated to reduce gaps and overlaps in services. *John B. Consent Decree p. 42.*

10. If a child is a TennCare enrollee and early intervention services are provided by TEIS, TEIS may seek reimbursement for these services if it or its providers have a provider contract with the MCO or BHO consistent with the policies and procedures adopted by TennCare, DOE, and this Agreement.

11. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, delay, termination, suspension, or reduction of medical assistance by the MCO or BHO. Appeals will be handled in accordance with procedures outlined in applicable State rules and as required by the *Grier* revised Consent Decree. *TennRule 1200-13-12-.11.*

G. Tennessee Department of Children's Services

1. No infant or toddler shall be denied early intervention services because of his/her status as a child in DCS custody. A DCS representative shall be present at the IFSP Team meeting for all children who are IDEA eligible in state custody.

2. DCS ensures that department personnel (i.e. case managers) have an opportunity to be trained to make appropriate referrals for infants or toddlers potentially in need of early intervention services. DCS shall also provide foster parents and DCS staff with information regarding Child Find, early intervention services, and the IFSP process. DCS does not provide any early intervention services. However, an agency representative shall be present at an IFSP Team meeting and facilitate the coordination of services in the IFSP and the infant or toddler's DCS Permanency Plan.

H. Tennessee Department of Mental Health and Developmental Disabilities

1. TDMHDD contracts with outpatient agencies to provide Regional Intervention Program (RIP) services. These RIP sites provide services for preschoolers and their families that meet the RIP eligibility requirements. Participation in RIP is not an entitlement and is subject to RIP eligibility requirements not IDEA Part C requirements.

2. RIP provides intensive parent training for families with preschool age children where there is a concern about their behavior.

3. TDMHDD shall ensure that personnel in the department, the Community Mental Health Centers (CMHC), and RIP sites have an opportunity to be trained to make appropriate referrals for infants and toddlers potentially in need of early intervention services. TDMHDD shall also provide staff with information regarding Child Find, early intervention services, and the IFSP process. TDMHDD encourages personnel at the CMHC and RIP sites to attend the IFSP meeting of an infant or toddler who is or may be eligible to receive RIP services and help facilitate the coordination of services.

I. Tennessee Division of Mental Retardation Services

1. The Division of Mental Retardation (DMRS) provides services for infants and toddlers who are eligible through the Home and Community Based Services (HCBS) waiver and state funded

services available on the basis of state appropriations. Access into the waiver is not guaranteed and is subject to funds available through state appropriations. Services funded by state appropriations are provided to those who are eligible in proportion to the availability of funds. *See Article 4 Section E - DMRS.*

2. DMRS funds a variety of early intervention services for infants and toddlers and their families through local contract agencies. Community based early intervention services are funded through DMRS and provided pursuant to contracts between the community organization and the State of Tennessee. DMRS services are not an entitlement program; therefore, payment for services will be based on the scope of services funded through the local contractor and space availability. *See Article 4 Section E - DMRS.*

3. Payment for an early intervention service that can be provided by DMRS or one of its contract providers and is appropriately documented on the family's IFSP is made on the basis of availability of state appropriations.

4. Early intervention services shall be provided at no cost to parents unless a system of sliding fees has been implemented by the Lead Agency (DOE). *34 CFR §303.521.*

5. Appropriate staff from the contract agency providing early intervention services will assist in developing a comprehensive IFSP. Services assigned to the contract agency will be provided in a family-centered manner.

6. The contract agency will participate in the development of an appropriate transition plan when the child turns two (2) years of age. The agency in cooperation with the Service Coordinator will ensure than an IEP is developed by the child's third birthday.

J. Resolution Mechanism

1. Any individual or organization may file a written complaint with DOE to resolve any systemic issues regarding the provision of early intervention services. *34 CFR §303.510(a)(1)(i).* DOE will investigate all IDEA Part C administrative complaints in the same manner as it does for Part B administrative complaints. *See Article 4 Section A - DOE, 34 CFR §303.512(a) & (b).* The written complaint must be signed and include a statement that the Participating Agency or any funded recipient has violated a requirement of IDEA Part C and must provide facts to support the complaint. *34 CFR §303.511.* The alleged violation must have occurred not more than one (1) year before the date that the complaint is received by DOE unless (1) the violation continues for that infant or toddler or other infants or toddlers; or (2) the complainant is requesting reimbursement or corrective action for a violation that occurred not more than three (3) years prior to the date of receipt of the complaint by DOE. *34 CFR §303.511(b).*

2. DOE, as lead agency, shall ensure that all due process hearings requested by parents to resolve issues of IDEA eligibility, evaluation, placement, or the provision of appropriate early intervention services will be conducted in accordance with all applicable state and federal statutes and regulations. DOE will maintain a list of state hearing officers and their qualifications. DOE shall appoint hearing officers. All due process hearings under IDEA shall be conducted consistently with state and federal law. *34 CFR §303.420.*

3. Upon request and with the consent of both the parent and the agency providing the early intervention service in dispute, DOE, as lead agency, will assign a mediator to resolve disputes arising under IDEA. DOE will appoint mediators and provide them with training in mediation and special education law. Consent to mediation by the parent of a infant or toddler who is IDEA Part C eligible is voluntary and will not delay or deny a parent's right to a due process hearing nor shall it deny parents any other rights afforded them under IDEA Part C. DOE shall bear the cost of the mediation process. Consistent with IDEA, all discussions that occur during the mediation process must be confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings. The parties to the mediation process are required to sign a confidentiality pledge prior to the commencement of the process. An agreement reached by the parties to the dispute in the mediation process must be set forth in a written mediation agreement. *34 CFR §303.419.*

4. During the pendency of any proceeding involving a complaint under Part C, unless the public agency and the parents otherwise agree, the infant or toddler must continue to receive the appropriate early intervention services currently being provided. If the complaint involves an application for initial services, the infant or toddler must receive those services in the IFSP that are not in dispute. *34 CFR §303.425.*

5. If a written complaint is received that is also the subject of a due process hearing or contains multiple issues, of which one or more are part of that hearing, the State must set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action must be resolved within the 60 calendar day timeline required for resolution of administrative complaints. *34 CFR §303.512(c)(1). See also paragraph one.*

6. If an issue is raised in a complaint that has been decided previously in a due process hearing involving the same parties, the previous hearing decision is binding. A complaint alleging that a public agency or private service provider failed to implement a due process decision must be resolved by the lead agency. *34 CFR §303.512(c)(2).*

7. Procedures for IDEA Part C dispute resolution permit agencies to resolve intra-agency disputes using their own procedures so long as resolution is accomplished in a timely manner. *34 CFR §303.523(2)(i).* DOE, as lead agency, is responsible for ensuring disputes are resolved in a timely manner. Therefore, when an agency is unable to resolve an intra-agency dispute in a timely manner, DOE, as lead agency, shall refer the issue to the informal resolution committee which will resolve the issue in accord with the procedures described in Article 6 of this Agreement. *34 CFR §§303.523.* DOE shall implement procedures to ensure services are provided in a timely manner pending the resolution of disputes among Participating Agencies or service providers by seeing that existing services are not disrupted or if initial services are in dispute that all other services other than the disputed one(s) are provided. *34 CFR §303.525.*

8. If there is a conflict between or among Participating Agencies (i.e. an interagency dispute) regarding the provision of or the payment for early intervention services, the procedure set forth in Article 6 of this Agreement shall be followed.

Article Six

Interagency Dispute Resolution Procedures

1. If any Participating Agency has any disagreement related to the payment for special education and related services, service responsibilities, or other matters related to this Interagency Agreement, the Participating Agencies agree to implement the following procedures. These procedures do not apply to individual administrative complaints initiated by a parent. Individual administrative complaints are resolved in accord with the procedures established by each agency as indicated in this Agreement. *See Articles 4 and 5.*

2. If an interagency dispute arises, the Participating Agencies agree to meet as a Resolution Committee whose purpose is to resolve disputes under this Agreement informally. This process can be initiated by any Participating Agency. If any entity other than the agencies participating in this Agreement has an issue with interagency implications, it may refer the issue by written notice to the agency with which it contracts or who provides oversight to its programs. The Participating Agency will evaluate the issue and refer the written notice to the Assistant Commissioner of Special Education for discussion by the Resolution Committee as appropriate. Each Participating Agency shall designate a representative and an alternate to serve on the Resolution Committee. The committee will only meet when a dispute arises. Each Participating Agency shall ensure that its representative or alternate participates in the Resolution Committee's deliberations even if the dispute at issue does not directly pertain to services provided by that Participating Agency. The committee shall meet as soon as practicable once the dispute arises and shall attempt to resolve the dispute in a timely manner. If a resolution is achieved, the committee shall write and distribute its findings of fact and conclusions. If the dispute cannot be resolved within fifteen (15) days of the referral, the issue shall be forwarded to the Commissioners Task Force

3. If an interagency dispute cannot be resolved informally in a timely manner, the aggrieved agency shall submit a written complaint to the Assistant Commissioner of the Division of Special Education. The complaint must include: 1) the regulation, policy, or requirement involved in the dispute; 2) the specific issue(s) needing resolution; 3) the prior actions taken to resolve this issue including a copy of the written findings of fact and conclusions of the informal Resolution Committee; and 4) any other information relevant to the complaint including but not limited to the child's IEP or IFSP, the relevant evaluations and assessments of the child, and all other supporting documentation. The Assistant Commissioner of the Division of Special Education shall forward a copy of the complaint to the members of the Commissioners Task Force (whose members include the Commissioners of the Departments of Education, Finance and Administration, Health, Human Services, Children's Services, and Mental Health and Developmental Disabilities, the Assistant Commissioner for Mental Retardation, and the Director of TennCare or their designees) within ten (10) business days from receipt of the complaint. Representatives of the Participating Agencies who serve on the Resolution Committee may not serve as the designee to the Commissioners Task Force. The Commissioners Task Force will meet within fifteen (15) business days from the receipt of the complaint by the Task Force. The Commissioner's Task Force will consider the written complaint including all documents submitted and oral arguments from the affected agencies. The Commissioners Task Force shall render a written decision within ten (10) business days after the meeting and distribute it to each Participating Agency. The Participating Agencies shall be responsible for ensuring that the written findings and conclusions are distributed to all offices, divisions, bureaus, units, and programs that may be affected by the findings. The final determination of the Commissioners Task Force shall be binding upon all the agencies. However, the decisions of the Task Force shall not be binding on future complaints but may be considered persuasive authority by the Task Force.

4. While the dispute is pending, the Commissioners Task Force may elect to assign financial responsibility to the agency currently providing the service at issue or if the service has not begun, the Task Force shall allocate resources from the Participating Agencies to provide the service, as appropriate. Once the dispute has been resolved, if the Commissioners Task Force determines that the assignment of financial responsibility was inappropriately made, it shall reassign the responsibility to the appropriate agency. The agency that was originally assigned financial responsibility may seek reimbursement for any expenditures incurred. Each Participating Agency shall establish such policies and procedures as are necessary to assure that any fiscal obligation assessed to it under this Agreement is timely paid or reimbursed.

5. A Participating Agency may refer a general policy question to the Commissioners Task Force for its review and recommendations. The Task Force shall make a policy determination in accord with the applicable state and federal laws and issue written findings that will be distributed to each Participating Agency. The Participating Agencies shall be responsible for ensuring that the written findings are distributed to all offices, divisions, bureaus, units and programs that may be affected by the findings.

Article Seven

Records

1. Pursuant to IDEA, FERPA, and all applicable state and federal laws, the following provisions will apply to the confidentiality and disclosure of education and medical records of IDEA eligible children under this Agreement.

   a. Consistent with state statute, records of students in public educational institutions shall be treated as confidential. Information in such records relating to academic performance, financial status of a student or the student's parent or guardian, medical or psychological treatment or testing shall not be made available to unauthorized personnel of the institution, to the public or to any Participating Agency, except those agencies authorized by the educational institution to conduct specific research, testing, evaluation, provide services or otherwise authorized by the governing board of the institution, LEA, or agency without the consent of the student involved or the parent or guardian of a minor student, except as otherwise provided by law or regulation and except in consequence of due legal process or in cases when the safety of persons or property is involved. The governing board of the institution, DOE, and the Tennessee higher education commission shall have access on a confidential basis to such records as are required to fulfill their lawful functions. Statistical information not identified with a particular student may be released to any person, agency, or the public; and directory information such as information relating only to the individual student's name, age, address, dates of attendance, grade levels completed, class placement and academic degrees awarded may likewise be disclosed. However, if it is disclosed, the directory information may not be linked with other non-directory information such as IDEA eligibility. *TCA§10-7-504 (a)(4).*

   b. Each Participating Agency or contractor which has access to a child with a disabilities education records must protect personally identifiable information at the following stages: collection, storage, disclosure, and destruction. One official in each Participating Agency shall be assigned responsibility for ensuring the confidentiality of all personally identifiable information. All Participating Agencies shall train or provide information to persons

collecting or using personally identifiable information on state law and procedures, IDEA, and FERPA requirements regarding the confidentiality of student education records. LEAs shall maintain, for public inspection, a current listing of all persons and their positions who have access to personally identifiable information within the Participating Agency. *34 CFR §300.572.*

c. Parents and legal guardians shall have complete access to their child's education records. Prior parental consent is required for disclosure of all personally identifiable information in a student's education record unless: 1) the disclosure meets the requirements of one of the FERPA exceptions enumerated in 34 CFR §99.31(a); or 2) if the disclosure is to an outside third party performing professional, business, and related services as a part of the operations of the educational agency or institution and has a legitimate educational interest in the information.

d. In order to have proper consent from a parent for the release of education records, the consent document must include the parent's: signature, date, listing of specific records to be disclosed, the purpose for the disclosure, and the parties or class of parties to which the disclosure will be made.

e. For the purposes of granting consent to release educational records or personally identifiable information, the rights of a parent are transferred to the student when the student turns eighteen (18) years old unless the child has been declared judicially incompetent under applicable state law. *34 CFR §300.517.*

2. Consistent with IDEA, FERPA, and all applicable state and federal regulations, an educational agency or institution shall comply with the following procedures regarding the disclosure of education records:

a. An educational agency or institution may disclose personally identifiable information from an education record of a student without parental consent if the disclosure meets one of the conditions set forth in 34 CFR §99.31(a) - FERPA Disclosure Exceptions. Although consent is not required for disclosure under one of the FERPA exceptions, FERPA generally does require the educational agency or institution to make a reasonable effort to notify the parents of the child that the information will be disclosed (i.e. in response to a subpoena). The parents shall have an opportunity to pursue protective action if the parent believes the disclosure is unwarranted. However, prior parental notification is not required prior to disclosure in response to a federal grand jury or law enforcement subpoena. FERPA does not compel or forbid the disclosure of education records in 34 CFR §99.31(a), but the child's right to privacy in the education records is a compelling state interest, and as such, the court places a high burden on the proponent of disclosure. A LEA may impose restrictions on the disclosure of educational records to another LEA or Participating Agency.

b. An educational agency or institution may disclose personally identifiable information to outside persons performing professional, business, and related services as part of the operations of the institutions if the educational agency or institution has determined that the person has a legitimate educational interest in the information. The privacy protections and confidentiality requirements imposed on the educational agency or institution extend to records and materials maintained by persons acting for the educational agency or institution such as an attorney, accountant or consultant. Improper disclosure by any individual receiving information under this provision will result in the denial of access to educational information by that individual for at least five years. *20 USC §1232g(b)(4)(B).*

c. The educational agency or institution may disclose education records to DCS without parental consent if the child has been placed in DCS custody and will be attending a school administered by DCS. While in the possession of a law enforcement unit, educational records do not lose their status as such.

d. Pursuant to IDEA, an educational agency or institution, when reporting a crime committed by a child with a disability in school to the appropriate authorities, shall transmit copies of the child's special education and disciplinary records. However, the transmittal of records shall only be to the extent allowed under FERPA. Disciplinary records are education records for the purposes of FERPA. *34 CFR §300.529(b).*

e. An educational agency or institution shall disclose education records to a due process hearing officer without parental consent if the disclosure is made in the course of the due process proceeding and not prior to it.

f. An educational agency or institution shall document and record to whom and for what purpose access to records was allowed. This record shall not include parents and authorized employees of the educational agency or institution. *34 CFR §300.565.*

3. Consistent with IDEA, FERPA, and all applicable state and federal regulations, student medical records shall be maintained in the following manner:

a. When maintained by an educational agency or institution for IDEA purposes, EPSDT records shall be considered educational records. An educational agency or institution shall not elect to categorize these records as anything else. If maintained by an educational agency or institution, school health and medical records shall be regarded as confidential education records. School health and medical records, as education records, include school performed screenings, exams, or assistance in the school health office; copies of medical or health related records submitted to schools when they are in the possession of the school; and receipt of services under IDEA.

b. The medical records of patients in state, county, and municipal hospitals and medical facilities, and the medical records of persons receiving medical treatment, in whole or in part, at the expense of the state, county, or municipality shall be treated as confidential and shall not be open for inspection by members of the public. *TCA §10-7-504.* The name, address, and other identifying information of a patient entering and receiving care at a licensed health care facility shall not be divulged unless the disclosure meets one of the enumerated exceptions in TCA §68-11-1503 (Medical Records - Confidentiality).

c. An educational agency or institute may not disclose personally identifiable information from a student's education record to TennCare without parental consent. Further, educational agencies or institutions may not provide TennCare with a list of all students who are receiving special education and related services to determine who is a TennCare enrollee. *20 USC §1232g(b)(1).*

4. Confidential education records shall be destroyed consistent with IDEA, FERPA and all applicable state and federal laws.

Article Eight

Amendments

This Agreement may be amended in writing upon mutual consent of all the Participating Agencies.

Article Nine

Term of Agreement

This agreement is effective upon execution by all Participating Agencies and shall remain in effect until it is terminated by any Participating Agency upon written thirty (30) day notice to the other Participating Agencies.

Article Ten

Waiver

A failure by any Participating Agency to exercise its rights under this Agreement shall not preclude that agency from subsequent exercise of such rights and shall not constitute a waiver of any other rights under this Agreement unless stated to be such in a writing signed by an authorized representative of the Participating Agency and attached to the original Agreement.

Article Eleven

Severability

If any provision of this Agreement or any provision of any document incorporated by reference shall be held invalid, such invalidity shall not affect the other provisions of this Agreement which can be given effect without the invalid provision, if such remainder conforms to the requirement of applicable law and the fundamental purpose of this Agreement, and to this end the provision of this Agreement are declared to be severable.

Article Twelve

Integration

This Agreement contains all the terms and conditions agreed upon by the Participating Agencies. No other understandings oral or otherwise regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the Participating Agencies.

Article Thirteen

Quality Review

Each Participating Agency shall designate liaisons who will meet annually to review the Agreement to ensure that the Agreement is meeting the needs of the Participating Agencies and recommend any changes or modifications which would benefit any of the Participating Agencies and or children with disabilities and their families. Personnel from the Participating Agencies will initiate a quality review of the services and conditions set forth in this Agreement. The Participating Agencies agree to review this Agreement one year from the date of its implementation and thereafter as needed to make such changes as they deem desirable.

Article Fourteen

Assignment

The services to be provided under this Agreement and any claim arising hereunder shall not be assigned or delegated by any Participating Agency, in whole or in part, without the express prior written consent of the other Participating Agencies which consent shall not be unreasonably withheld.

Article Fifteen

Construction

This Agreement is in no way to be construed as limiting or diminishing the responsibilities of the Participating Agencies under federal or state law. In all instances, this Agreement is to be construed to comply with the requirements of federal and state law. This Agreement shall not be construed to create rights in any third parties.

APPROVED BY:

Vernon Coffey, Commissioner
Department of Education

10/18/00
Date

Mack E. Reynolds, Deputy Commissioner
Department of Finance and Administration
Bureau of TennCare

10/25/00
Date

C. Warren Neel, Commissioner
Department of Finance and Administration

10-27-00
Date

Barbara Brent, Deputy Commissioner
Department of Finance and Administration
Division of Mental Retardation Services

10/19/00
Date

George W. Hattaway, Commissioner
Department of Children's Services

10/24/00
Date

Fredia Wadley, Commissioner
Department of Health

10-25-00
Date

Natasha K. Metcalf, Commissioner
Department of Human Services

Date

Elisabeth Rukeyser, Commissioner
Department of Mental Health and
Developmental Disabilities

10/20/00
Date

EFFECTIVE DATE: November 1, 2000

Attachment One

Acronyms

BHO	Behavioral Health Organization
CIT	Children's Information in Tennessee
CMHC	Community Mental Health Center
CSS	Children's Special Services
DCS	Tennessee Department of Children's Services
DHS/DRS	Tennessee Department of Human Services/Division of Rehabilitation Services
DMRS	Tennessee Division of Mental Retardation Services
DOE	Tennessee Department of Education
DOH	Tennessee Department of Health
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FAPE	Free Appropriate Public Education
FERPA	Family Educational Rights and Privacy Act
HCBS waiver	Home and Community Based waiver
ICC	Interagency Coordinating Council
ICF-MR	Intermediate Care Facility - Mental Retardation
IDEA	Individual's with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
IPE	Individual Plan for Employment
ISC	Independent Support Coordinator
ISP	Individual Support Plan
ITP	Individualized Transition Plan
LEA	Local Educational Agency
MCO	Managed Care Organization
PCP	Primary Care Physician
RIP	Regional Intervention Program
RMHI	Regional Mental Health Institute
SEA	State Educational Agency
TCA	Tennessee Code Annotated
TDH	Tennessee Department of Health
TDFA	Tennessee Department of Finance and Administration
TDMHDD	Tennessee Department of Mental Health and Developmental Disabilities
TEIS	Tennessee Early Intervention System

Attachment Two

TennCare Release Form

TennCare

RELEASE OF INFORMATION

FOR INDIVIDUAL EDUCATION PLAN

Please be advised that permission is given for _____
(name of school)

to release information concerning :

_____
Full Name of Child

_____
Social Security Number

I understand that the information released will be in the form of an Individual Education Plan (IEP) for this child, which identifies his/her need to receive medically necessary services in an educational setting. This information will be released to the child's TennCare Managed Care Organization (MCO), TennCare Behavioral Health Organization (BHO), and his/her Primary Care Provider (PCP) so that appropriate services will be provided to this child. Confidentiality of this information is required by contract and will be made available only to those individuals directly concerned with this child's diagnosis, care and treatment.

_____
Parent/Guardian Signature

_____
Date

_____
Witness Signature

_____
Date

Attachment Three

TEIS Release Form

AUTHORIZATION FOR PROCUREMENT AND RELEASE OF INFORMATION FOR STATE DEPARTMENTS PF HUMAN SERVICES, HEALTH, MENTAL HEALTH AND MENTAL RETARDATION AND EDUCATION AND RESPECTIVE AGENCIES NAMED BELOW IN THIS DOCUMENT

Name of Child: _____ Date of Birth: _____

Name of Legal Guardian: _____ ID#: _____

Address: _____

(Name of Direct Care Provider)

☐ to obtain from _____ to release to _____ to exchange with _____

(Person or agency) (Phone number)

the following information through written form and/or oral discussion of impressions or recommendations.
Parent initial the appropriate boxes.

☐ The complete record including:
- intake forms
- progress notes
- reports
- assessments/evaluations
- discharge summary

☐ IFSP/Reviews
☐ Psychological Reports
☐ PT Reports
☐ Other:

☐ OT Reports
☐ Most Recent Neurological
☐ Family Needs Assessment
☐ D/C Summary
☐ Hearing Screening/Evaluation
☐ Vision Screening/Evaluation
☐ Medical Reports
☐ Social History
☐ Immunization Record

Reason for request _____

Consentor Rights – You have a right to refuse to sign this form. You have the right to refuse to release information to the individual or agency listed above. You have the right to express limitation on the use of the information to be released. The following records may not be released:

_____

_____

_____

_____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released without my written consent. I understand these reports may have information on communicable diseases.

Effective one (1) year from date signed or until:
I understand that I may revoke this consent at any time.

(Date) (Signature of Parent/Legal Guardian) (Signature of Witness/Title)

No individual shall be denied equal educational opportunity because of his/her color, handicap, religion, marital or parental status, national origin, race or sex. (Revised May 14, 1999)

ATTACHMENT E
TSOP ON INTERPERIODIC SCREENINGS (DRAFT)

DRAFT - For Review & Comment Purposes ONLY

STATE OF TENNESSEE
DEPARTMENT OF FINANCE & ADMINISTRATION
BUREAU OF TENNCARE
729 CHURCH STREET
NASHVILLE TENNESSEE 37247-6501

MEMORANDUM

DATE:

TO: **TennCare MCOs & BHOs** **TSOP: draft 094**

FROM: **Mark E. Reynolds**
Deputy Commissioner

SUBJECT: Interperiodic Screenings

The Social Security Act (the Act), as amended by OBRA 89, requires that under the EPSDT benefit, state Medicaid programs must provide for screenings, including vision, hearing, and dental screenings, at intervals which meet the reasonable standards of medical and dental practice. The Bureau of TennCare has adopted the periodicity schedule recommended by the American Academy of Pediatrics (AAP) for Preventive Pediatric Health Care. Per the TennCare/MCO/BHO contracts, MCOs and BHOs are required to furnish EPSDT screenings, diagnostic, and treatment services to all TennCare-eligible children under the age of 21 at periodic intervals of the child's life.

In addition, section 1905(r) of the Act requires that "interperiodic" screens be provided when necessary and this strengthens the preventive nature of the EPSDT program by providing screening, diagnostic, and treatment services between otherwise scheduled examinations. An "interperiodic" screen is a partial screening conducted outside of the regularly scheduled periodic screening. The interperiodic screen gives attention to the suspected problem to determine if additional diagnostic and treatment services are needed. There would be no need to complete all of the required components of a regular EPSDT periodic screen if written verification exists to show that the most recent age-appropriate screening services, due under the AAP periodicity schedule, has already been provided to the member.

The determination of whether an interperiodic screen is necessary may be made by a health, developmental, or educational professional who comes in contact with the child outside of the formal health care system (e.g., Early Intervention Programs, Head Start, and nutritional programs such as the Special Supplemental Food Program for Women, Infant and Children). Likewise, parents, guardians, or family members can make determinations of whether an interperiodic screen is necessary when it is suspected that a child is having problems. For example, a child who is screened at age 10 according to the periodicity schedule for EPSDT screenings would not be due for another screening until age 11. However, if six months later the child's schoolteacher suspects that the child is

having hearing trouble the schoolteacher should immediately refer the child to a primary care provider (PCP) for an *interperiodic screen* to determine if there is a problem that needs further attention. There is no need to wait until the next regularly scheduled *periodic screening*.

Contractors may not impose prior authorization requirements on periodic screens or interperiodic screens conducted by the primary care provider and must provide all medically necessary, TennCare-covered services. While there is no requirement that EPSDT periodic or interperiodic screenings be medically necessary, additional testing and treatment services must meet the medically necessary criteria.

Follow-up is just as important as the screening. Providers who perform EPSDT periodic and interperiodic screens may identify potential health, developmental, or behavioral problems and they are responsible for making referrals to other MCO and BHO providers to do further testing or to provide treatment, as appropriate.

ESPDT periodic and interperiodic screens are not subject to cost sharing responsibilities, however, cost-sharing responsibilities may apply to diagnostic and treatment services if the member has cost-sharing responsibilities. Contractors should assist with the scheduling of periodic and interperiodic screens when requested and provide transportation to said screens as appropriate.

TennCare Authority:

42 U.S.C §§ 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)
42 C.F.R. § 440.230
42 C.F.R. § 441, Subpart B
HCFA's State Medicaid Manual
TennCare Rules and Regulations 1200-13-12-.04(1)(w)
TennCare/MCO Contract Section 2-3.a.1.; Section 4-8.
TennCare/BHO Contract Section 2.6.1.; Section 5.3.3.1.

TennCare Contact Person:

Regarding:

Medical Issues	Karen Oldham, M.D.	(615) 741-0213
Quality of Services	Ken Okolo	(615) 741-1145
Policy	Kasi Tiller	(615) 741-0160
Contract Compliance	Jack Welch	(615) 532-6743
EPSDT Coordinator	Kasi Tiller	(615) 741-0160

KT/das

ATTACHMENT F
DCS EPSDT REPORT

STATE OF TENNESSEE
Department of Children's Services
Policy, Planning and Research Division
7TH Floor, Cordell Hull Building
436 Sixth Avenue North
Nashville, Tennessee 37243-1290

MEMORANDUM

TO: Mary Beth Franklyn

CC: George Hattaway, Commissioner
Bo Irvin, Deputy Commissioner
Steve Leonard, Assistant Commissioner, Finance and Administration

Jules Marquart	Terry Bassham
Mary E. Walker	Debra Valentine
Carla Aaron	Albert Dawson
Lisa Faehl	Dottie Hagood
Christa Martin	Paul Vander Meer
Marilyn Hayes	Margaret Dorse
Cathy Rogers-Smith	Bill Evans
Sandra Burke	Bill Beecroft
Ken Steverson	Jerry Tidwell
Nancy Patterson	Donna Duncan
Leonard Burton	Regional Administrators
Jane Chittick	CSA Executive Directors
Susan Steppe	Field Systems Administrators
Sherry Abernathy	Health Units
Ron Neal	

FROM: Hsin-Hui Lin, Manager, and John Roberts, Data Analysis Unit
Policy, Planning and Research

DATE: January 24, 2000

RE: EPSDT Reports for October 2000

Attached is the EPSDT report for the month of October 2000. The information for the attached reports was obtained using the TN KIDS extract pulled on January 16, 2000. The total number of children to be screened excludes those children who are in Youth Development Centers, on runaway status or in a detention center and are therefore not available to be screened.

The October report consists of three charts. Table 1 reflects the number and percent of children that had been in custody 30 or more days who had an EPSDT screen by the end of October. This report represents the cumulative percentage of children in the Department of Children's Services custody who have a current EPSDT screen. By the end of October, the EPSDT exam completion rate for children in custody was 86.29%. This represents an 1.5% increase over the cumulative completion rate of 84.84% for September 2000. Regional completion rates varied from 74% in Davidson County to 96% in the Knox and Northwest regions. Seven regions show a completion rate over 90% -- Knox 96%, Northwest 96%, Hamilton 95%, Southwest 93%, Southeast 92%, East Tennessee 91%, and Mid Cumberland 90%. The region showing the greatest increase is the Mid Cumberland region by almost more than 6%.

Table 2 shows the number of children over age three who had been in custody 30 days or more who had been given a dental screening by the end of October. The statewide percentage of children with dental exams was 75.03%. This represents almost a 3% increase over the cumulative completion rate of 72.28% for September 2000. Almost 57% of children in Davidson County and 58% in Shelby County had received dental screens. This contrasts with Knox County where nearly 95% of children in custody had the needed dental screen. The Mid Cumberland regions shows an 8% increase and Hamilton County has a 5% increase over the previous month.

Table 3 shows the number of children who entered state custody during October 2000, the number of these with prior EPSDT screens, the number needing a screen, and the number and percentage of screens completed within 30 days of entering care. According to departmental policy, all children in custody at least 30 days need a screen within 30 days of entering custody. We have changed how the numbers are calculated on children entering custody during the month who are eligible for an EPSDT screen. In the revised analysis for the first column, we have excluded children who entered custody and stayed less than 30 days during this reporting period.

The percentage of children with EPSDT exams completed within the first 30 days of entering custody was 53.06%. This represents a 3% decrease over the 30-day completion rate of 56.47% for September 2000. Regions varied widely, from 13% of EPSDT exams within 30 days reported in Davidson County to 82% of children in the Southeast region receiving exams within 30 days. Southeast region has shown a 24% increase in the 30-day completion rate since the previous month. The low numbers in some regions may be caused by data entry delays.

Attachments

Table 3: Department of Children's Services EPSDT Screens Completed within 30 Days for Children Entering Custody During October 2000

Region	*Total Number of Children Entering Custody	Number of Children with EPSDT Screens within the Past 365 Days	Total Number of Children Entering Custody Needing EPSDT Screens	Number of Children with EPSDT Screens Completed within 30 Days of Entering Custody	% with EPSDT Screens Completed within 30 Days
Davidson	40	1	39	5	12.82%
East Tennessee	71	7	64	49	76.56%
Hamilton	29	2	27	20	74.07%
Knox	23	7	16	13	81.25%
Mid Cumberland	60	10	50	23	46.00%
Northeast	42	10	32	26	81.25%
Northwest	31	1	30	20	66.67%
Shelby	41	8	33	5	15.15%
South Central	24	0	24	13	54.17%
Southeast	21	4	17	14	82.35%
Southwest	38	7	31	16	51.61%
Upper Cumberland	30	1	29	4	13.79%
Department Totals	450	58	392	208	53.06%

*Note: Children who entered custody and stayed less than 30 days during this reporting period were not included in this column as being eligible for the EPSDT screen.

Data pulled from TN KIDS extract dated 1/16/01

Tennessee Department of Children's Services
Policy, Planning and Research Division
Tuesday, January 23, 2001

Table 2: Department of Children's Services Completion Rates of Dental Screens by Region as of October 31, 2000 (Cumulative)

Region	Children Age 3+ to be Screened	Number of Children with Dental Screens Completed with the Past 365 Days	% with Dental Screens Completed within the Past 365 Days
Davidson	754	427	56.63%
East Tennessee	864	735	85.07%
Hamilton	494	437	88.46%
Knox	465	440	94.62%
Mid Cumberland	1,184	898	75.84%
Northeast	672	507	75.45%
Northwest	228	193	84.65%
Shelby	1,434	827	57.67%
South Central	539	408	75.70%
Southeast	474	391	82.49%
Southwest	630	549	87.14%
Upper Cumberland	495	365	73.74%
Department Totals	8,233	6,177	75.03%

Data pulled from TN KIDS extract dated 1/16/01

Tennessee Department of Children's Services
Policy, Planning and Research Division
Tuesday, January 23, 2001

Table 1: Department of Children's Services Completion Rates of EPSDT Screens by Region as of October 31, 2000 (Cumulative)

Region	Total Number of Children to be Screened	Number of Children with EPSDT Screens Completed within the Past 365 Days	% with EPSDT Screens Completed within the Past 365 Days
Davidson	843	622	73.78%
East Tennessee	935	848	90.70%
Hamilton	548	518	94.53%
Knox	531	510	96.05%
Mid Cumberland	1,317	1,186	90.05%
Northeast	728	614	84.34%
Northwest	250	239	95.60%
Shelby	1,647	1,257	76.32%
South Central	588	499	84.86%
Southeast	535	493	92.15%
Southwest	693	646	93.22%
Upper Cumberland	565	489	86.55%
Department Totals	9,180	7,921	86.29%

Data pulled from TN KIDS extract dated 1/16/01

Tennessee Department of Children's Services
Policy, Planning and Research Division
Tuesday, January 23, 2001

ATTACHMENT G
PROPOSED SURVEY QUESTIONS FOR THE BHO CONSUMER SATISFACTION SURVEY

The following is a draft coordinated care survey item developed by AdvoCare staff from CMHS resources, submitted to the Tennessee Justice Center and currently under review by advocacy groups:

DRAFT Of Proposed Items Related to Coordinator Care, BHO Consumer Satisfaction Survey

1. Are you a parent or guardian of a child under the age of 18 or the parent or guardian of an adult under the age of 21?

____ Yes (Please go to question 2.)
____ No (please skip to question 9)

2. Besides mental health professionals, has your child or family been involved with other agencies such as DCS (Dept. of Children" Services), juvenile justice, education, etc?***

____ Yes (Please go to question 3).
____ No (Please **skip to question 9)**

In thinking about the coordination of your child's services, please rate how much you agree or disagree with each statement.

	Does not Apply	Strongly Disagree	Disagree	Agree	Strongly Agree
3. Staff from the different agencies worked together to plan services for my child and family.	0	1	2	3	4
4. The agencies worked well together in planning services.	0	1	2	3	4
5. All agencies that needed to help were involved.	0	1	2	3	4
6. The agencies involved me in the planning process in a meaningful way (*such as goal setting and choice of services).*	0	1	2	3	4
7. The agencies involved my child in the planning process in a meaningful way. (*Such as goal setting and choice of services).*	0	1	2	3	4
8.Overall, I am satisfied with the coordination of services by the agencies for my child.	0	1	2	3	4

(Questions 2-8 derived from Marco International, Inc. CMHS National Evaluation, Follow Up Assessment Caregiver (I), January 8, 2000, p. 4-7).***

ATTACHMENT H
REVISED REMEDIAL PLAN

REVISED REMEDIAL PLAN
FOR CHILDREN IN CUSTODY

EXECUTIVE SUMMARY FOR REVISED REMEDIAL PLAN

The organization of this plan places the EXECUTIVE OVERSIGHT COMMITTEE (state and plaintiff representatives) as the group with the ultimate responsibility of overseeing the progress of the plan and making recommendations to the court. However, the STEERING PANEL (representatives of providers, advocates, state and plaintiffs, managed care entities, and referral sites) is the group with the expertise to provide input from many different perspectives for the direction of this plan. A smaller working group of the Steering Panel has agreed to provide more frequent input for the development of this revised plan as well as during the implementation. The Steering Panel will oversee a needs assessment, direct the development of a data system, monitor progress and make the recommendations to the Executive Oversight Committee for the development of a system that will meet the health needs of these children. The HEALTH SERVICES TEAM (same as the Implementation Team in the previous agreement) will consist of an administrator / case manager, pediatrician, mental health professional and clerical support. This team will provide not only staffing for the above two groups, but will be involved in negotiating contracts, providing options for the best practice guidelines, and overseeing operational details that must be established between the partners/stakeholders to carry out this plan. The team also has the responsibility of authorizing covered, medically necessary services for children in custody and those at imminent risk of custody, who have had services denied by a BHO or MCO. (When services have been denied for this group of children, the Health Services Team has the authority to determine the services clinically indicated and authorize the services to begin. An appeal will be filed to determine if the state or the managed care entity is responsible for payment, but the child will receive the services in timely manner.)

The Steering Panel met regularly from June, 2000 through November, 2000 and voted November 2, 2000 to direct the state to seek a Carve -Out arrangement for the children in custody. It was the opinion of the Steering Panel that the Remedial Plan finalized in May, 2000 could not be implemented with TennCare in its current state of transition. Not all the Tertiary Pediatric Centers, which were to be designated the Centers of Excellence, had the behavioral health capacity to handle a significant number of referrals. The centers feared that community providers would refer all children in custody to them because this population is the most difficult to manage. The centers also feared that the infrastructure grants provided to build behavioral health capacity and the reimbursement from the managed care entities for services provided to these children might still generate significantly less funds than the cost of being a safety net provider. However, the one point about which the centers would not negotiate, was the Remedial Plan's requirement that each center contract with all TennCare MCOs and BHOs operating in their area. The centers felt this requirement decreased their negotiating power with the

managed care entities as well as forced them into contracts with entities with which they had experienced problems.

Private pediatricians also refused to participate if they had to agree to accept all TennCare children referred to them, whether in state custody or not, which was a prerequisite for participation. They feared that few providers would participate and those who did might have children in custody referred from several counties and overwhelm their practices. They also refused to participate in all MCOs in their geographic area for reasons quite similar to those expressed by the Tertiary Pediatric Centers.

The Steering Panel felt that the children in custody have very special needs and timely services are of utmost importance. These children need intensive services often as much for social problems as medical problems. The average medical managed care model operates on "medical necessity" and not a combination of "medical and social necessity." The Panel recommended that these children be carved out of the TennCare multiple managed care entities and served in a manner more responsive to their needs and through a mechanism where the managed care entity makes health care decisions based upon the child's health care needs rather than on the entities' financial risk. The Panel also directed the state to continue efforts to increase the capacity of health care services for all TennCare children in Tennessee as it worked to meet the specific needs of this subclass.

Under the Revised Remedial Plan, the state would contract with one MCO and one BHO to provide statewide services for children in custody and a certain group of children deemed at "prolonged risk" of custody. The contracts for these entities would represent more of a management model and put the state at financial risk for services. The Steering Panel felt this model would allow for recruitment of providers and referral sites.

Instead of Centers of Excellence being developed only at Tertiary Pediatric Centers, there is now the option of developing the behavioral health referral site either at a Pediatric Tertiary Care Center, with a private psychiatric group or another entity. The contracting entity must agree to provide a safety net for mental health assessments of children in custody or at risk of custody and must develop care plans and work with community providers to implement the care plan. The state will develop a contract with these sites to increase mental health capacity, to provide consults to community providers and to develop training programs for providers.

The Best Practice Network Primary Care Providers will be community pediatricians and family practice physicians who agree to provide EPSDT exams in a timely manner, manage all health care including coordination of referrals for needed assessments or subspecialty care, and serve as an advocate for children in custody to assure they get appropriate care. They will receive an enhanced EPSDT rate as well as an appropriate monthly case management fee sufficient to cover the

time the PCP spends in outreach and care coordination efforts on behalf of the child. With the Carve-Out plan for these children, the providers only have to sign with one MCO, and be familiar with one set of procedures, forms, and formulary in order to be included in the Best Practice Network for these children. These providers must agree to use Best Practice Guidelines when developed and attend training sessions.

The Revised Remedial Plan has additional components designed to address problems identified during the past six months of Steering Panel meetings:

A. *Community Mental Health Capacity needs to be enhanced.*
The state will fund at least 20 mental health providers for communities across the state. These individuals will serve children in custody as their priority clients to provide timely appointments and the level of care needed. These providers will be required to attend ongoing training relative to the mental health problems of children in custody and appropriate management according to Best Practice Guidelines.

B. *Community Mental Health Centers may not have the expertise for certain children and yet do not refer these children for care at another site.*
The mental health system in Tennessee, and the one used in the TennCare model, is based on Community Mental Health Centers providing assessments, case management, and care. There is a concern that when CMHCs do not have the capacity to provide more frequent or more intense services, they do not order this and they do not refer to another provider. If services are not ordered, the BHO never has to deny services, and there is no appeal issued. The DCS Health Units have part-time mental health professionals (usually a psychologist) in each of the 12 regions of the state to assist in emergency assessments and care when needed. This plan would increase the contractual arrangements so that there is at least one full-time equivalent mental health professional for each of the 12 regions of the state. These professionals could evaluate any child in custody who was felt by the Best Practice Network Primary Care Physician (PCP), a DCS worker, or member of the Health Services Team to need more intense services. If this DCS mental health professional then orders a more intense level of care (or more frequent visits) and the CMHC could not comply, then the BHO would be responsible for finding the level of care needed.

C. *Plaintiff's attorneys were concerned because in the previous Plan For Children at Serious Risk of Entering State Custody, DCS had sole discretion in deciding who was at serious risk of custody and eligible to receive additional services.*
To respond to this concern, the Revised Plan for Children at Serious Risk of Entering State Custody adds a non-governmental advocacy component that will have services in five locations of the state to answer a hotline and assist families who need behavioral health services for their children. This support service will assist in getting eligible children enrolled in TennCare, will refer families for services, and will make referral to the Health Services Team when they feel there is a serious risk of custody and BHO/MCO services are being

denied. The Health Services Team can then determine the child to be at serious risk of custody and eligible for targeted case management and other services designed to prevent custody. DCS still has the responsibility of determining if children coming to their attention are at serious risk of custody, but the Advocacy group and the Health Services Team now provide another avenue for this occur.

D. *Children transitioning out of custody should spend a longer period of time within the Carve-Out MCO/BHO arrangement to decrease the likelihood of recidivism. Moving the child back and forth from the custody managed care arrangement to the regular TennCare managed care entities could impede continuity of care and increase the risk of the child reentering state custody.* To answer this concern, the Revised Plan extends the usual period of transition with all benefits from 3 months to a minimum of 6 months; this period can be extended for as long as needed by the child; plus, there is an added component allowing children to be deemed at "prolonged risk" of custody and remain in the Carve-Out arrangement indefinitely.

E. *With a Carve-Out arrangement, the plaintiffs feared there might be an incentive for families to place children in custody in order to obtain better mental health services.*

1. The Health Services Team is in place to assist children in regular TennCare BHOs and MCOs who are at imminent risk of state custody get the services they need.
2. In the Plan For Children At Serious Risk of Entering State Custody, children at serious risk of custody can receive targeted case management services as well as in-home services just like children in custody.
3. Children who are deemed at "prolonged risk" of custody can be placed in the carve-out arrangement and receive all services that a child in custody would receive and in the same manner.
4. The advocacy component has been added as an outreach to find and refer children to the Health Services Team in addition to referrals from DCS, so that children might be deemed "at serious risk" of custody and provided additional services to prevent the necessity of custody.
5. With the additional community health capacity, there should be less perceived need to put children in custody for services.
6. The state is pursuing other opportunities to enhance the mental health system for children in communities that would increase capacity for all TennCare and low-income children.

F. *Medicaid dental networks across the country have been inadequate and often need creative efforts to expand capacity for children.*

The state will expand the dental services capabilities in certain local health departments as the first step in enhancing dental health capacity for children in custody. This effort will actually require new sites in some geographic areas and a higher reimbursement rate for all services. However, for the long term dental access problem, TennCare is actively pursuing the feasibility of establishing a Carve-Out for all dental services, including an enhancement of

TennCare funds earmarked specifically for the dental component. While this may allow for the recruitment of more private dentists, it has proven to be insufficient in other states to totally meet the needs of Medicaid clients. Therefore, TennCare will work with the dental Carve-Out entity and local health departments to create new providers for dental services in health departments, in federally funded dental clinics, or by using mobile units.

Although the first Remedial Plan could not be implemented during the past six months, a great deal has been accomplished. Problems relative to the existing behavioral health system have been identified from the different perspectives of all the Steering Panel members and the work of the Implementation team. Their input for resolving the problems has been incorporated into the Revised Remedial Plan as well as new components to respond to the concerns of the Plaintiffs'.

REVISED REMEDIAL PLAN

I. PRINCIPLES

A. Children in state custody often have a greater incidence of physical, behavioral, and developmental problems. This is a plan which begins the development of a system that provides the services needed for these children and offers a process for making changes and improvements. This plan and process are guided by the following principles:

1. Complete EPSDT screening exams are needed on entrance into custody to allow for appropriate planning of any care that might be needed.
    a. Screenings done by the primary care providers encompass the seven components required by federal guidelines using tools approved by the EPSDT advisory committee. Those components are: (1) A comprehensive health and development history to include both physical and mental health; (2) Comprehensive unclothed physical exam; (3) Appropriate vision and hearing assessment; (4) Laboratory tests appropriate for age and risk; (5) Dental screening and referral beginning at age 3; (6) Immunizations; (7) Health education (anticipatory guidance).
    b. Dental screenings after age three will be arranged with private dentists or local health departments.
2. Appropriate care should be provided as close to the place of residence as possible and build upon the patient's and family's strengths and needs.
3. Specialty and dental care should be available to meet all needs of these children.
4. Service coordination or case management is a critical component for any health system of children in custody or at imminent risk of entering custody – both while the child is in custody and during the phase of transitioning out of custody.
5. A health system for children in custody should be designed to allow for evaluation of the system as well as health outcomes of the children it serves.

6. The flow of health information within the system must allow for all providers, DCS, and the MCO/BHO to appropriately manage the care of children.
7. The system must include a sufficient array of services to assure that a child's needs are met on an individualized basis, building upon the child's and family's strengths and, to the degree possible, furthers the goals of the permanency plan.
8. As the system is developed, Best Practice Network Providers will be recruited and Best Practice Guidelines will be established and followed.
9. Since behavioral health issues are prevalent in this group of children, an emphasis should be placed on this component of care with attention given to building capacity.
10. Tertiary Pediatric Centers (TPC) should have a far greater appreciation for this population's total health needs based upon their medical expertise and role in the medical community at large, and will be encouraged to participate in this plan and build behavioral health capacity.
11. The input of caregivers is needed to design a system for children in custody.
12. Unmet needs of TennCare eligible children for health/ behavioral health services should not influence legal custody status.
13. All parties having a role in the provision of health/behavioral health services will act as an integrated, collaborative team collectively serving in the best interest of the child including, but not limited to, the Best Practice Network providers, the TPC, the Managed Care Organization, Behavioral Health Organization, and the Department of Children's Services.

II. DEFINITIONS

A. "Carve-Out for children in state custody" (carve-out) refers to an arrangement that TennCare establishes so that all children in state custody and a certain group of those at risk of state custody (as defined in this document), are assigned to one MCO and one BHO. TennCare will contract with these managed care entities to provide services for these children but with less financial risk than traditional TennCare arrangements

B. A "Tertiary Pediatric Center" (TPC) is a site recognized by the services it offers to be a referral site for children needing the highest level of

physical care. While some of these sites have played a significant role in providing behavioral health services for children referred from private physicians, some have not. The five sites which currently are recognized as tertiary care centers for pediatrics are in Johnson City, Knoxville, Chattanooga, Nashville, and Memphis.

C. Behavioral Health Services include mental health services as well as services for management of alcohol and drug use/abuse.

D. "Behavioral Health Referral Centers" (BHRC) can be either a TPC, private psychiatric group, or other entity which contracts with the state to develop the behavioral health capacity needed to serve as a safety net to provide assessments and care plans for children in custody. The BHO will still be responsible for having within its network (or locating) the services that might be ordered by such a referral site. While the original Remedial Plan had only five referral sites using the Tertiary Pediatric Centers, if there are entities willing to meet the terms of this remedial plan in providing safety net services and are felt to be important for better care of children in custody, nothing precludes the development of more than five Behavioral Health Referral Centers.

E. The term "Best Practice Network" (BPN) refers to a group of providers (primary care, behavioral health, and dental) who have agreed to participate in the Carve-Out MCO/ BHO network and to provide appropriate care for children in custody in accordance with the terms of this Revised Remedial Plan and statewide Best Practice Guidelines.

F. The term "Children with Special Health Needs Steering Panel" (CSHN Steering Panel) refers to an entity comprised of those members identified in this Remedial Plan whose responsibility will be to guide and assess the development of a health service system for children in state custody and, where appropriate, make recommendations to the Executive Oversight Committee.

G. The "Executive Oversight Committee" is composed of the Director of TennCare (or his supervisor in Finance and Administration), the Commissioner of the Department of Children's Services, the Commissioner of Health, plaintiffs' attorneys, defendants' attorneys, a representative from the Behavioral Health Referral Centers, and an agreed-upon consultant. It will have primary oversight for the implementation of this plan.

H. "Medically necessary" (definition in MCO and BHO contracts as read consistent with the *John B.* Consent Decree.)

I. "Screenings" – the initial 7 component EPSDT examinations to determine if there are problems, or suspected problems and the screenings by dental providers after the age of three.

J. The term "at imminent risk of entering custody" shall mean those children who are at risk of entering state custody as identified by a court pursuant to Title 37, Tennessee Code Annotated.

K. As used in this plan, "covered services" refer to TennCare covered medical and behavioral health services. The term "covered services" does not include services that:

1. Are subject to an exclusion that has been reviewed and approved by the Federal Health Care Financing Administration and incorporated into a properly promulgated state regulation, OR
2. Under Title XIX of the Social Security Act, are never federally reimbursable in any Medicaid Program.

III. ESSENTIAL COMPONENTS OF HEALTH CARE SYSTEM

A. Best Practice Network within the Carve-Out MCO and BHO

1. There will be three categories in the BPN:
   a. The primary care providers (PCPs), who not only administer basic health care, but also coordinate all physical and behavioral health care of children assigned to them. They maintain all health records regardless of where the care was provided.
   b. Behavioral health providers consisting of: (1) existing staff of Community Mental Health Centers (CMHCs); (2) additional mental health professionals which will be added to the communities with the greatest mental health needs to improve access to services of children in custody as a priority population; (3) private providers contracted with BHO; (4) staff of BHRCs; (5) the mental health providers on contract with DCS to assist Health Units.
   c. Dental providers (both public and private) recruited to serve children in custody.
2. The roles of the Best Practice Providers will be as follows:
   a. Role of the Primary Care Providers
      1) Provide EPSDT screenings
      2) Provide not only the basic health care, but also care coordination of all the health care services of children in custody

3) Refer to physical and behavioral health professionals in Best Practice Network for specialty care; refer to the CMHC and BHRC when indicated; coordinate referrals with MCO/BHO.
4) Request telephone consultations with BHRC when indicated.
5) Communicate with caregivers on plan of care.
6) Maintain all health information on children assigned to them regardless of who provides the care (BHRC, local specialist, behavioral health provider).
7) Report to the DCS Health Unit any time health information on a child is not forwarded in a timely manner to allow for appropriate evaluation and care. (This will be done within the confines of the federal confidentiality laws. A protocol will be developed for the sharing of health information among the providers of this system.)
8) Forward medical files to the newly assigned PCP when a child is being transferred to a new geographical area.
9) Share health information with DCS and foster parents within confidentiality guidelines.
10) Forward pertinent information to providers seeing children on referral.
11) Utilize (and document usage) Best Practice Guidelines for care when developed and adopted by CSHN Steering Panel and Executive Oversight Committee and document rationale for variation from Best Practice Guidelines.
12) Review information provided by state or MCO/BHO on caring for children in custody.
13) Participate in the evaluation of system and outcomes through representation on the CSHN Steering Panel.
14) Participate in the MCO/BHO selected for children in custody.
15) Participate in training arranged by the state or the BHRC relative to health problems of children in custody or Best Practice Guidelines.
16) Develop health treatment plans and incorporate all the

treatment needs of the children they see.

b. Role of the Behavioral Health Providers in BPN

(1) DCS will expand their contracts to assure that a full-time mental health professional is working with their Health Units to provide the following services.

(a) Provide assessments for custody children whenever the PCP or DCS determines them to be the most appropriate evaluator in the community for certain children due to their expertise on children;

(b) Provide assessment when no other provider in region can do so in a timely manner;

(c) Provide consult to PCP or DCS when there is concern that a child is not receiving services appropriate for his/her need by other providers in the region;

(d) Provide a second opinion in cases where the HST disagrees with the service(s) ordered by a mental health provider. If the second opinion differs from the service(s) ordered, the HST can request the BHO to cover the service(s) authorized by the second opinion. If the BHO denies the service(s) authorized by the second opinion, or otherwise fails to provide the service(s) in a timely fashion, then the HST can issue a letter of authority authorizing the service(s) in accordance with Section IX (A) (4). Where possible, the HST should attempt resolving the matter with the BHO prior to issuing a letter of authority.

(e) Consult child psychiatrist at BHRC when this level of expertise is needed.

(2) Role of CMHCs and private providers in the network: The state will make available no less than 20 mental health professionals for communities with the greatest mental health needs for children services, and these will be dedicated to serving children in custody as their first priority with any child on TennCare as the next priority. These individuals will function differently by being more

in the community and connected to the PCPs in the Best Practice Network. It will be the goal to have these behavioral health staff seeing clients in the offices of BPN PCPs. This will provide better integration of services and make access to services easier for families. It is recognized that the caseload of each PCP will vary and the practicality of this arrangement may not be as great for some PCPs as others. The state will work with PCP's and CMHCs to design these collaborative arrangements. This does not preclude another site being used for services when it is deemed appropriate for the improvement of services to children and their families. The state will have the option of placing these mental health professionals with other entities which are willing to assist in the effort to increase community mental health capacity. These mental health professionals will be required to attend ongoing training relative to the mental health needs of children in custody and the resources available in the community for these children. Services provided by these individuals will be billed to the BHO but the state will underwrite the amount of salary, benefits and other costs not covered by the reimbursements for services provided. The role of the CMHCs staff, private providers and additional staff provided through the state will be:

a. Provide assessments and behavioral health care when referred by PCP and clinically indicated.
b. Forward information concerning assessments or care to PCP in BPN.
c. Forward information to other providers in network and at BHRC when they are seeing children in custody.
d. Provide input on Best Practice Guidelines.
e. Utilize the Best Practice Guidelines as established and adopted and document their use in medical record.
f. Assist the CSHN Steering Panel and the BHO in evaluating patient outcomes as well as the health care system established to serve children in state custody.

g. Participate in TennCare BHO selected for children in custody.
h. Participate in training arranged by the state or BHRC.
i. Review information received from state or BHO about procedures for children in custody.
j. Coordinate care with BHO (eligibility checks, concurrent review/development of treatment plans when indicated)
k. Participate in development and implementation of health treatment plans for children they serve in custody.

c. Role of Dental Providers

Dental providers will provide screenings to children over three years of age and also any care that is needed within their scope of practice and competency. Since there are a limited number of participating dentists in the TennCare program, (a) the state will provide the funds necessary to allow local health departments to initiate or enhance dental services in areas where space is available and the need for capacity is greatest; (b)TennCare will also provide reimbursement to these sites on a fee schedule acceptable to both TennCare and the Department of Health as adequate to cover the cost of the operation for serving children in custody. Other public, non-profit clinics such as federally funded primary care clinics will also be sought as providers under this arrangement; (c) The enhanced EPSDT dental screening fee will also be available for private dentists who participate in TennCare and serve children in state custody.

In order to staff these clinics, the health department may employ dentists in state positions or through county contracts; contract with private dentists for after hours or weekend hours; seek volunteer dentists; seek arrangement with dental schools; or utilize dental hygienists along with dentists to maximize capacity where feasible. It is understood that the success of this component depends upon the availability of dentists to contract or be employed for his purpose.

B. Behavioral Health Referral Centers (BHRCs)

There have been no recognized tertiary care centers for behavioral health services for children in Tennessee such as the five that exist for physical health services. Some private child psychiatrist groups have served a greater role as a referral site for children in custody (as well as other TennCare children) than the Tertiary Pediatric Center (PTC). For this plan, either the TPC, a private child psychiatrist group or another entity may contract with the state to be a BHRC. The state will contract for no less than three years with the entity so long as contract terms are met. Contract changes will be negotiated each year as necessary.

The centers will develop capacity to serve as a safety net for assessments and care plans for children in custody, as well as children at "imminent" risk of custody This capacity may consist of additional psychological, psychiatric or case management services. The intent of the contracts is to provide an infrastructure to cover services that may not be readily available to the BHO (psychological evaluations, follow up consultations with providers or DCS, assisting caregivers in meeting needs of the child). Contracts will be signed with centers which can provide quality care at a reasonable cost.

The BHRCs will be available to serve those children (whether in custody or at imminent risk of custody) who are in need of an emergency assessment and recommendations or orders for services most appropriate for the child and this cannot be obtained, or cannot be obtained in a timely manner, within the community. The infrastructure funds to the centers will be to provide dollars for additional staff as well as agreed upon operational and indirect costs to serve these children. However, since the number of children who will need to be referred to these centers can only be determined with experience, the initial year contract can be amended (midyear). This amendment will occur when a center can show that the infrastructure funds and the reimbursements for services are not covering the costs agreed upon to serve the children referred under this plan. The infrastructure grant can be adjusted each year to more accurately reflect the amount needed in addition to reimbursements to provide services to children in custody or those designated by the state as at risk of custody and referred to the centers. It will be the intent of the state to have the Carve-Out BHO cover more of the costs for mental

health services for these children to decrease the need for infrastructure funds. It will be included in the contracts that any unused time of the staff provided through these contracts must be used for other TennCare children referred for behavioral health services.

1. There are five tertiary pediatric centers in Tennessee which have always functioned as the referral sites for children with complicated medical and developmental problems. Some have pediatric psychiatric units as a function of their training capacity, but the referral pattern for children in custody has often been through the Community Mental Health Centers. In some metropolitan areas, private psychiatrists have provided most of the care for children in custody when they were referred out of the Community Mental Health Center system. The intent is to develop a system of care that utilizes the TPCs appropriately.
2. The role of the TPCs will be different in the various areas of the state and depend upon the capacity of the center as well as the willingness of the TPC to participate as the referral site for behavioral health services for children in custody. Some will have a child psychiatrist that provides consults for the participating community behavioral health providers; they will also accept referrals for children in custody and at imminent risk of custody; they will provide diagnostic services and care plans for some and ongoing consultations with providers for others. However, some TPCs might not have the capacity for behavioral health services, might not want to enter a contract with the state for this function, or might not be willing to negotiate a reasonable rate for the services needed. In such a case, private psychiatric groups can be utilized for this function where available, competent and willing.
3. The Behavioral Health Referral Centers:
    a. Will provide one representative each for the CSHN Steering Panel.
    b. Have one member represent them on the Executive Oversight Committee.
    c. Provide training to providers and DCS staff as arranged through a contract with the state
    d. Recommend Best Practice Guidelines for behavioral health problems to Steering Panel

e. Act as safety net to provide assessments and care plans for children in custody referred to them
f. Work with DCS in developing protocols for direct referral to the BHRC.
g. Provide follow-up contacts with caregivers, providers, and DCS to assure compliance with care plans for children seen.
h. Provide consultations to providers on children in custody.
i. Assist BHO in the recruitment of behavioral health providers in areas where there is an inadequate network, by providing names of providers willing to participate.
j. Notify Health Services Team when BHO denies services felt to be medically necessary for children in custody.

C. **Health Services Team** – HST (formerly Implementation Team)

1. The Health Services team plays a broader role in the Revised Remedial Plan relative to authorizations for services denied by an MCO or BHO. During the past six months it has become apparent that authorizing services involves a great deal of communication between providers, DCS, the court and the managed care entities. Having multiple entities assume this role (the five Centers of Excellence were to do this for children in custody and the Implementation Team for children at risk of custody in the original agreement) would create confusion, inconsistency and duplicated effort. Therefore, under the Revised Remedial Plan, one entity, the Health Services Team, will review MCO and BHO denials or delays for services as provided for elsewhere in this plan, and authorize those services it determines to be appropriate under the circumstances.
2. The Health Services Team is expressly granted access to the medical records (physical or behavioral) of those children the Health Services Team is required to assist in accordance with this plan. All of the medical records obtained by the Health Services Team shall be held in the most strict confidence, and shall not be released to any individual unless the requesting individual is expressly granted such access by law, or unless the Health Services Team is ordered to release them by a court of competent jurisdiction.
3. Determine when children referred to them are at imminent risk of

custody and need additional services provided to this group to prevent custody. (DCS will still perform this service also.)

4. Act as ombudsmen for children in custody or at risk of custody by working with providers, DCS, agencies serving children, and courts to get consensus on what is best for the child and family; to assist in getting that services approved by the BHO or DCS;
5. Identify areas where provider networks are inadequate from the problems the team experiences in obtaining services for children at risk of custody as well as those in custody. Recommend to MCOs and BHOs (both for the custody children and the other children in TennCare) where networks are inadequate. Recommend to MCOs and BHOs qualified providers willing to contract with the network.
6. Staff the Steering Panel as well as the Executive Oversight Committee.
7. Assist in negotiations for contracts needed to implement the Revised Remedial Plan.

D. Managed Care and Behavioral Health Organizations

1. One representative from each will participate on the CSHN Steering Panel.
2. Recruit and contract with an adequate number of providers for Best Practice Network with expertise in children's health problems in accordance with TennCare standards and the criteria of this plan.
3. Contract with BHRCs for care needed at this level.
4. BHO will contract with the private mental health professionals working with DCS Health Units, the 20 mental health professional provided by the state (or the the CMHCs or entities that are employing these staff) and the BHRCs.
5. Recruit for areas identified by the Health Services Team as having an inadequate network; contract with qualified and willing providers identified by the Health Services Team for areas (geographical or specialty) where shortage is identified; OR if consensus cannot be reached with Health Services Team on what constitutes a network inadequacy, demonstrate adequacy of network to Executive Oversight Committee.
6. Develop procedure for assigning children in custody to BPN providers; work with Steering Panel to develop best policy and mechanism for maintaining a long standing relationship between a child and a PCP or mental health provider, when family along with providers or the state feel that disruption of this relationship would

be detrimental to the child. This is especially critical for children with severe physical or behavioral problems with a long term relationship with the provider.

7. Assist in developing Best Practice Guidelines.
8. Continue to manage and be responsible for all aspects of the TennCare program as specified in contracts with TennCare.
9. Work with state to develop those services determined to be necessary by CSHN Steering Panel and Executive Oversight Committee to be needed.

E. TennCare Bureau Responsibilities

1. Contract with one MCO and one BHO, each with a statewide network that has expertise for children's physical, developmental and behavioral problems to provide care management services to children in custody and children at "prolonged risk" of custody (to be defined by the Steering Panel) using fee for service structure and an arrangement which decreases the financial risk for the MCO and BHO.
2. Establish the mechanism to cover capital expenditures for dental operatories in local health departments with the capability to establish or expand dental services, and arrange with the MCO to pay health departments according to an agreed upon fee schedule; arrange for private providers to receive the same enhanced EPSDT screening rate as health departments.
3. Develop a mechanism to underwrite the costs for supplemental behavioral health staff to be placed in communities and a plan for evaluating the effectiveness of this strategy.
4. Contract with the BHRC for any services needed to implement this plan (for child psychiatrist, training, other functions as negotiated)
5. Fund any part of needs assessment felt to be required by the CSHN Steering Panel and the Executive Oversight Committee.
6. Require MCO and BHO to provide adequate encounter and financial data to determine the provided services and the cost of those services for children in custody.
7. Provide resources for staffing the CSHN Steering Panel and Health Services Team.
8. Participate on the CSHN Steering Panel and the Executive Oversight Committee (the latter representative must be either the

Director of TennCare or his supervising official in the Department of Finance and Administration).

9 Require the MCO/BHO to include in its subcontracts with providers a provision which states that the subcontractors are forbidden from encouraging or suggesting, in writing or verbally, TennCare children be placed into state custody to receive medical or behavioral treatments. But instead, they are to let families know that there are other options and refer them to the Health Services Team when they are unable to get behavioral health services and are at risk of coming into custody.

10. Resolution of Payment Issues for TennCare Covered Services.
    a. When a covered service has been requested by a health care provider, and the MCO/BHO has denied or otherwise failed timely to provide that service or approved a less intense service which the provider or DCS feels is inadequate, the Health Services Team will be contacted for disposition:
        1) If the Health Services Team member determines that the MCO/BHO approved service is adequate then no change will be made. (If the service fails in the judgment of the DCS staff, the Health Services Team member can be contacted for a reassessment of the situation.)
        2) If the Health Services Team member agrees with the provider that a more intense service is needed, the HST will authorize the ordered service. Where practicable, the HST will utilize a qualified provider in the MCOs/BHOs network. However, a network provider will not be utilized if the Health Services Team, in the exercise of its sole discretion, determines any of the following:
            a) There is no time to locate a network provider under the circumstances,
            b) A network provider is not available to provide the services in a timely fashion,
            c) Available network providers are not qualified to deliver needed services, or
            d) Utilizing a network provider would otherwise jeopardize the health of the child in need of services.

3) Whenever the Health Services Team authorizes the services under this provision, the HST will give the willing provider an authorization letter for services which will assure reimbursement, it will notify the MCO/BHO of the decision, and will file an appeal. Should the decision on appeal be in favor of the MCO/BHO, the state will be responsible for reimbursement of those services. Should the decision be rendered against the MCO/BHO, the MCO/BHO will be assessed the cost of the service denied. However, the outcome of that process shall not affect the interests of the child, who shall receive the services in question without regard to whether the MCO/BHO or a state agency is ultimately determined to be financially responsible.

b. When a covered service has been requested by a health care provider (especially in the context of a juvenile court proceedings) and Health Services Team believes the service is not intense enough, the HST can request a DCS mental health professional to provide a second opinion. If the second opinion differs from the service(s) originally ordered, the HST can request the BHO to cover the service(s) authorized by the second opinion. If the BHO denies the service(s) authorized by the second opinion, or otherwise fails to provide the service(s) in a timely fashion, then the HST can issue a letter of authority authorizing the service(s) in accordance with Section IX (A) (4). Where possible the HST should attempt resolving the matter with the BHO prior to issuing a letter of authority.

12. Reimbursement for services provided for children transitioning out of custody:
    a. During the period when children are transitioning out of custody, the state will continue all the services for a child in custody. The child will also remain in the MCO and BHO designated for children in custody.
    b. These services will continue for six months routinely on all children. When a child goes home for a 90 day trial but is still in custody, this will count for the first three months of transition time. The above services can also be

continued for an additional six months on a case by case basis for a total of 365 days from the time of custody termination for those children whom DCS or PCP and the Health Services Team deem it appropriate to prevent them from returning to state custody. Children will be tracked by DCS to determine the recidivism rate for children with extended transition services.

c. Children Who Remain at Risk of Custody.
The past history and/or the current diagnosis and prognosis may indicate that a child will always require intense services to remain out of custody (ie...certain sexual perpetrators, etc). The Behavioral Health Best Practice Guidelines Committee of the CSHN Steering Panel will recommend to the Executive Oversight Committee the diagnoses and the process that should be used for determining which children might need to remain in the carve out MCO/BHO and continue receiving case management services due to their risk of returning into state custody. A panel including one behavioral health professional, one pediatrician, and one member chosen from the Executive Directors of Tennessee Voices for Children, Tennessee Commission on Children and Youth or other recognized group representing children, shall make the determination of who qualifies for this category. A similar panel will also review these cases every two years to determine if the level of services is still needed to require the child to be in the carve-out MCO/BHO.

13. Arrange with BHO for custody children to have advantage of Continuous Treatment Teams when determined to be needed to maintain the child in the home.
14. Develop a process whereby children who are already enrolled in TennCare but may not be assigned to the custodial MCO/BHO will be reassigned as soon as TennCare has been informed that the child is in state custody or is at risk of state custody and should be placed in the custodial MCO/BHO.

E. Department of Children's Services Responsibilities

1. Maintain responsibility of seeing that children in custody receive appropriate health services, including arranging the appointments

for screenings. Report on number of children receiving EPSDT screenings in timely fashion.

2. Provide care coordination and case management consistent with the *John B* Consent Decree and Medicaid regulations, as described below.
3. Provide a representative to the CSHN Steering Panel.
4. The Commissioner participates as a member in the Executive Oversight Committee.
5. For services provided through DCS, assure that these services are provided with reasonable promptness to meet individual needs.
6. Amend its provider contracts/policy manuals to include a provision which states that DCS contracted entities are forbidden from encouraging or suggesting, in writing and verbally, that TennCare children be placed into state custody to receive medical or behavioral treatments. Instead they are to make caregivers aware of the alternative option and how they can contact the Health Services Team for assistance in getting behavioral health service.
7. Expand contracts with mental health professionals working with Health Units to have at least one full time equivalent per region.
8. Track children in custody in order to determine recidivism; relate to length of time of the transition period and what services were provided. Provide information on children who receive services to prevent custody and the outcome of such services.
9. Provide training to staff to carry out the components of this plan.
10. Continue process with the Working Group of the Steering Panel to determine support systems needed by DCS case managers to enhance their ability to better serve children with Severe Emotional Disturbances.

IV. CASE MANAGEMENT

A. Department of Children's Services. Care coordination is now provided by DCS case managers while a child is in custody. The DCS health units assist them in making referrals and obtaining care for children. The Role of DCS in Case Management will be:

1. Assuring appointments are made for EPSDT and referrals for care. This role will include transportation for these services.
2. Assuring assessment and care plans always get to PCP.

3. Assuring appropriate medical information always gets to provider who is doing consultation or specialty care.
4. Contacting the BHRC for appointment when needed.
5. Maintain responsibility for seeing that services for children in custody identified by the PCP are coordinated, and that appointments with the medical or behavioral providers are made and kept.
6. Coordinate with other child-service agencies in the community including working with school or child care staff when indicated for meeting needs of the plan of care; DCS will attend school meetings when an Individual Education Plan is developed when possible and advocate for child, providing information regarding medical or behavioral health issues when appropriate; when the child is not progressing and the problem could be related to an existing behavioral health issue, the DCS behavioral health provider will be asked to assess and determine if the treatment plan should be adjusted or further evaluation is needed.
7. Arranging for transfer of records from one PCP to another when a child is being transferred to another geographical area; records will be forwarded before transfer if possible but within a week otherwise.
8. Seeking consults from their own contracted mental health professionals or BHRC when DCS feels the child is not making progress as expected.
9. Arranging services for children transitioning out of custody and assuring targeted case management for those children who have received ongoing behavioral health services during custody; arranging targeted case management for children who qualify because they are at imminent risk of custody.
10. Regional Health units will follow-up on any complaints that information concerning custody children is not getting to providers in a timely manner to provide appropriate evaluation and care.
11. DCS will develop a monitoring tool designed to track the number of children returning to custody, the reasons for return, and the length of time from termination of custody to re-entry, to be utilized by the CSHN Steering

Panel and the Executive Oversight Committee in reviewing the issue of services provided to children transitioning out of custody.

12 When care plans are developed by Best Practice Network Providers or BHRC, case managers will incorporate care plans in staffings held for the child, and will access services consistent with needs identified in the care plan.

B. Primary Care Providers in Best Practice Network Responsibilities for Case Management

The PCP is the case manager in the health network because this is the provider that all children have. The role of the PCP will be:

1. Maintain all the health information on the children including behavioral health. (A protocol will be developed for the system to allow for sharing of information within the confines of the federal laws for confidentiality.)
2. Coordinate health services and be the case manager requesting assistance from DCS case manager in following up and assuring plan of care is implemented.
3. Consult with BHRC or other behavioral health providers when additional help is needed in managing a case.
4. The PCP must always be notified when a child is transitioned out of custody (as well as the behavioral health provider if applicable) and requested to follow the child more closely. The PCP will notify DCS when he/she feels more intense case management (as defined by *the John B* Consent Decree and Medicaid regulations) is needed by DCS and this will be noted on the child's data record at DCS for tracking and evaluation purposes.

C. Behavioral Health Referral Centers

1. The BHRC will be developing the behavioral health care plans for the children they see. Since they may be a great distance from the place of residence of the child, the PCP is in a better position to coordinate health services and see that the treatment plan is implemented. The BHRC may be asked to provide consults to community providers for guidance in implementing the care plan. Behavioral health treatment plans will be generated using the BHO-approved format. The BHO will be involved in

health treatment plans when coordination of referrals and intense follow-up is required.

TPCs have always been the safety net for all children with significant medical or developmental problems. This will continue with children in custody. These centers see some children now with behavioral health problems and may choose to contract with the state to be a safety net for behavioral health services under this plan and function as a BHRC. However, when children in custody are referred to a TPC for physical problems needing diagnostic services or ongoing care, the care plan will be obtained by DCS or the referring PCP to assure that recommendations for the child will be implemented. But as with the BHRC, the PCP will be the care coordinator for the health services in the community.

D. Department of Health Responsibilities for Case Management

1. The Department of Health has existing programs designed to support children in school as well as pre-school children at risk. When DCS is unable to meet the needs for case management for children transitioning out of custody or at risk of custody, and asks DOH for assistance on a case, DOH will provide care coordination and support services. A contract with TennCare will be developed for this service if shown to be needed.
2. DOH will establish a Health Services Team that reports to the Commissioner which will consist of:
   One administrator/ case worker and clerical support
   One pediatrician
   One mental health professional for consultations
   a. The health professionals of this team will serve as ombudsmen to assist children and families in crisis get the health services that are appropriate to meet their needs;
   b. Authorize services denied by managed care entities for children in custody or at risk of custody, when the team deems these services medically necessary;
   c. Determine when children referred to them are at

serious risk of custody and should have enhanced services to prevent the need for custody and notify DCS of determination.

d. Make reports to the CSHN Steering Panel and Executive Oversight Committee concerning the type of cases referred to them, and barriers to care encountered.

e. A telephone number will be established to handle these referrals and the number will be publicized with notification to include: Tennessee Voices for Children, DCS staff, MCOs and BHOs, foster parent groups, providers, and Tennessee Early Intervention System.

E. Case Management of Children at Imminent Risk of Custody

1. Through DCS a case manager is assigned when a child comes to the attention of the court and the judge orders a behavioral health assessment.

2. These children are reported to the HST by DCS in order that the team can monitor and assist in getting services needed for court.

3. The case manager monitors progress of evaluation and care plan completion in order to be prepared for court date. The evaluating mental health professionals will be trained and encouraged to forward recommendations at least 5 days before court date.

4. Case managers will work with BHO to have services which have been recommended.

5. HST will be contacted when the BHO denies services recommended as well as when DCS mental health professional believes the service ordered is not intensive enough for the best interest of the child and family.

V. TRACKING

The tracking system is to allow evaluation of the system as well as assessing the quality of care of children. The major questions that a tracking system must answer are (a) Are needs for custody children being identified? (b) Are services being delivered in a timely manner? (c) Are outcomes documented (including school performance where relevant)?

(d) Are re-assessments made in a timely manner when progress is not made according to the care plan? (e) Are revisions of health treatment plans and permanency plans made when progress is not made? The Department of Children's Services has the TNKIDS data system designed and implemented in all areas of the state. This system is unique and could possibly contain all, or most, of the components needed to meet the two objectives. A group representing various entities of state government, the academic centers, plaintiffs' attorneys and individuals with expertise in program evaluation will review the system to determine:

A. If elements should be added to this system which will assist in evaluating services for children;
B. If additional information is needed for evaluation, and ways to retrieve this data;
C. Who can (feasibly and legally) have access to this system; and
D. What enhancements need to be made to meet the evaluation needs established by the CSHN Steering Panel

The state will also explore the feasibility of a "health tracking" data system that is Internet based and could link all providers of the BPN.

VI. STEERING AND MONITORING COMPONENTS

A. A Children with Special Health Needs Steering Panel will be appointed to advise on the development of the health system for children in custody.
    1. The Role of the Children with Special Health Needs Steering Panel.
        a. Develop a plan for building the best practice network.
        b. Direct a needs assessment to determine the resources and gaps in services for children in custody; and the educational needs of providers.
        c. Determine components needed for monitoring and tracking system:
            (1) Review TNKIDS database of DCS and C-PORT of Tennessee Commission on Children and Youth; recommend modifications of these to enable monitoring of this remedial plan;
            (2) The feasibility of developing an electronic tracking system which would contain all health information on custody children and could be monitored to determine the quality of the system as well as the progress and outcomes of individual

children will be studied. The CSHN Steering Panel will review any plan that is developed and make a recommendation regarding the feasibility and effectiveness.

(3) If the total electronic tracking system is not felt to be feasible, or if it is to be developed but will take more than one year, then the CSHN Steering Panel will recommend a methodology for determining if children are receiving appropriate care.

d. Adopt/develop recommended Best Practice Guidelines.
e. Adopt/develop a recommended behavioral health screening tool.
f. Adopt a process to assure quality in the system.
g. After assessing needs of system and progress made during Year 1, recommend to Executive Oversight Committee additional goals, objectives, and time lines for Year 2.

2. In order to complete these duties, there will be staffing provided for the CSHN Steering Panel by the TennCare Bureau.
3. Members of the CSHN Steering Panel will include:
   a. Commissioner of Health
   b. Commissioner of Mental Health/Developmental Disabilities or designee
   c. Representative of TennCare
   d. Representative of DCS
   e. Representative from each BHRC
   f. Five practicing pediatricians
   g. Two Mental Health Professionals, one from a Community Mental Health Center
   h. Dentist recommended by Tennessee Dental Society
   i. MCO Medical Director and BHO representative with expertise in children's behavioral health issues
   j. Attorney for plaintiffs
   k. Attorney for defendants
   l. An appointment by plaintiff's attorneys who has expertise in children's health issues
   m. Foster parent
   n. Representative of Tennessee Voices for Children
   o. Representative of Tennessee Commission on Children and Youth

4. The members may wish to establish committees and ask various health professionals, representatives from various groups, or individuals with specific areas of expertise to work with a subcommittee to assess or plan on a particular component of the plan. These panel members may elect by 2/3's majority vote to add up to three members to the CSHN Steering Panel.
5. Because behavioral health issues are prevalent and often severe in children who are in custody, the CSHN Steering Panel will appoint a Behavioral Health Subcommittee (whose members need not be on the Panel) to address: BPN, protocols for Diagnostic and Evaluation Centers (Primary Treatment Centers); Best Practice Guidelines; and innovative strategies for building behavioral health capacity in rural areas.
6. This panel will convene meetings as frequently as necessary to complete its task but will also maximize teleconferencing whenever possible.

B. Executive Oversight Committee
   1. This committee will consist of:
      a. Director of TennCare or the supervising official of the Department of Finance and Administration
      b. Commissioner of the Department of Children's Services
      c. Commissioner of Health
      d. Plaintiffs' and defendants' attorneys
      e. Consultant (agreed upon by State and Plaintiffs)
      f. One representative from the BHRCs
   2. This Executive Oversight Committee will have primary oversight for this remedial plan and will:
      a. Monitor the progress of the Remedial Plan.
      b. Negotiate any modifications to the Plan and the Agreement.
      c. Review the recommendation from the CSHN Steering Panel, including recommendations for Phase Two or Year 2; finalize Year 2 goals; objectives and time lines for the remedial plan.

VII. SAFETY NET ISSUES

A. The MCO/BHO must work to establish and maintain a provider network with adequate capacity to deliver covered services which meet the special needs of children in state custody. Indicators of an adequate

network for these children include:

1. The MCO/BHO meets the guidelines established by its contract with TennCare for a provider network;
2. The MCO/BHO has enough providers to consistently meet the time lines of this plan for EPSDT screenings;
3. The MCO/BHO has sufficient types and numbers of providers to be able to consistently deliver services in a timely manner when ordered for a child.

B. Failure to Maintain Adequate Capacity in Network and Recruitment of Best Practice Network Providers. The MCO and BHO will recruit Best Practice network providers who have appropriate credentials, are willing to follow BPN guidelines and are willing to participate in their networks. DCS will report any incidences where providers are not available to deliver services within the time frames specified for EPSDT screenings or within the timeframes specified as needed by the Best Practice Network Provider or BHRC to the Health Services Team. The HST will keep records and report to the Executive Oversight Committee in what areas of the state an inadequate network exists. The MCO/BHO will be notified when reports indicate a network deficiency and when recruitment of additional providers is necessary. When the Health Services Team identifies that a network is inadequate (in a geographic area or in a specialty) and the HST has identified a qualified provider available and willing to participate in the network, the MCO or BHO must contract with that willing provider or demonstrate to the satisfaction of the Health Services Team that their network is adequate according to above criteria. Consistent with the regulatory framework established by this plan, decisions made by the Health Services Team pursuant to this part are ultimately subject to review by the Executive Oversight Committee.

C. System Safety Net Features

By use of a Carve-Out arrangement, it will now be less difficult to recruit and develop a Best Practice Network. However, the following safety net features will be in place.

1. EPSDT Screenings
    a. Physical health screenings - The local health departments will serve as safety net providers until the BPN is fully developed. With the carve-out arrangement, the MCO can also elect to pay a provider that is not in its network the

enhanced rate to do the EPSDT screenings until the network is developed.

b. Dental health screenings - Local health departments, in which dental services are available, will provide safety net services. The state will provide the capital for enhancing dental capacity within local health departments where there is a great need for access to services. An enhanced EPSDT dental screening rate will be paid to the local health departments as well as any network dentists. Whenever the dental network is inadequate and dental care is urgent, out-of-network providers will be utilized to provide the care. (TennCare will be notified to enforce standards regarding network adequacy.) TennCare will also pursue a carve-out of all dental services as a long-term measure for the dental access issues.

2. Primary Care Providers

During phase one or the first year of operation, if a BPN PCP is not available, a provider who is willing to be a PCP for custody children at the same rates, then this provider can be utilized. When a child has an established relationship with a provider who is not in the BPN, but is willing to continue care for this child and is qualified and competent to provide the care, the MCO will allow the PCP to continue to provide care and reimburse at the same rates as network providers.

3. The Behavioral Health Services Safety Net will consist of:
   a. The mental health professionals underwritten by the state to enhance community mental health capacity
   b. The full-time mental health professionals who contract with DCS to provide emergency evaluations and services
   c. The five Behavioral Health Referral Centers that the state contracts with to be a safety net for children in custody.
4. The Safety Net for any child who is severe, acute, or has complicated medical or developmental problems will continue to be the Tertiary Pediatric Centers.
5. The Health Services Team within the Department of Health will provide safety net services as described above under III.C. by reviewing services denied to children in custody and at risk of custody to determine if they are medically necessary. If so, the team can authorize a provider to initiate services with a guarantee of payment..

6. The Department of Children's Services will contract for in-home and community services for children at risk of custody in an effort to eliminate the need for custody.

VIII ASSURANCE OF TIMELINESS OF ASSESSMENT

A. When children come into custody, DCS will determine if they have TennCare. If they do not have TennCare, DCS will enroll them within 3 days by determining traditional Medicaid eligibility or by enrolling them as an uninsured at the county Health Department.

B. When children come into custody, DCS will determine if they are appropriate for a non-treatment setting, such as a foster home, emergency shelter, relative home, or whether due to immediate determination of treatment or safety issues, they should be referred to the regional PTC.

C. DCS will schedule appointments for EPSDT screenings within 3 days of being enrolled on TennCare or as soon as a PCP is assigned.

D. Best Practice Network providers will be informed that custody children are eligible for TennCare or, as applicable, private insurance or DCS is otherwise billed for services. BPN providers will be educated not to refuse screenings to custody children for unavailability of TennCare ID cards.

E. DCS will provide copies of TennCare ID cards or otherwise provide BPN providers with eligibility information for purposes of billing TennCare.

F. DCS will schedule permanency planning staffings within 21 calendar days of children coming into custody. DCS will incorporate both EPSDT screenings and behavioral screenings into the permanency planning process and initial and ongoing treatment plans, as well as medical services and other federally required components of the Permanency Plan. If a youth is in a contract placement, the contract agency is responsible for assurance that EPSDT services are coordinated, the health treatment plan is implemented, and needs are met, with communication and collaboration with the home county case manager and the child's PCP. In Departmental foster homes, the case manager, in cooperation with the foster parent, assures that the EPSDT services are coordinated and services provided as indicated.

IX. CHILDREN DEFINED BY STATUTE AS AT IMMINENT RISK OF ENTERING CUSTODY.

A. Process: The following process will be utilized with respect to TennCare covered services for children who are at imminent risk of entering custody.

1. DCS informs judge (and the family) of its options for providing services for non-custodial children which might possibly prevent the necessity of state custody. These will include:
    a. Implementing a package of services designed to keep the child in the home while necessary behavioral health services are being provided
    b. Utilizing an out of home placement if necessary to have the child evaluated for services
2. DCS informs the HST of any children that come to the attention of the court and custody determination is being delayed until the judge can see if suitable arrangements can be worked out for the child and family.
3 HST follows the child along with DCS, the BHO and the evaluating provider(s) to make sure the best plan is reached for the child. When services are ordered and the MCO/BHO deny or otherwise fails to provide services in a timely fashion, the HST may authorize services and file an appeal to determine whether the managed care entity or the state is responsible for the cost of the service.
4. Options for Out-of-Home Placement
    a. DCS gets a provider to determine the level of care needed for the child
    b. The BHO is contacted for approval of the service ordered.
    c. If the BHO denies or otherwise fails to provide the services in a timely fashion, the HST is contacted and will proceed as follows:
        1) If the Health Services Team member believes that the BHO-approved service plus DCS family support services are adequate, he will contact the provider and see if consensus can be reach, at least for a trial.. (If the trial fails in the judgment of the DCS staff or a behavioral health provider, the Health Services Team member can be contacted for a reassessment of the situation.)

2) If the Health Services Team member agrees with the provider that a more intense service is needed, the HST will authorize the ordered service. Where practicable, the Health Services Team will utilize a qualified provider in the BHO's network. However, a network provider will not be utilized if the Health Services Team, in the exercise of its sole discretion, determines any of the following:
    a) There is no time to locate a network provider under the circumstances,
    b) A network provider is not available to provide the services in a timely fashion
    c) Available network providers are not qualified to deliver needed services, or
    d) Utilizing a network provider would otherwise jeopardize the health of the child in need of services.

3) Whenever the Health Services Team authorizes the services under this provision, the HST will notify the BHO of the decision, and will file an appeal. Should the decision on appeal be in favor of the BHO, the state will be responsible for reimbursement of those services. Should the decision be rendered against the BHO, the BHO will be assessed the cost of the service denied.

4) Whenever a covered service has been requested by a health care provider (especially in the context of juvenile court proceedings) and the Health Services Team believes the service is not intense enough, the HST can request a DCS mental health professional to provide a second opinion. If the second opinion differs from the service(s) originally ordered, the HST can request the BHO to cover the service(s) authorized by the second opinion. If the BHO denies the service(s) authorized by the second opinion or otherwise fails to provide the service(s) in a timely fashion, then the HST can issue a letter of authority authorizing the service(s) in accordance with Section IX (A) (4). Where possible the HST should attempt to resolve the matter with the BHO prior to issuing a

letter of authority

5. Option for Package of Services Designed to Keep the Family and the Child at Home.
    a. Targeted Case Management Services
        1). DCS will arrange for targeted case management services for non-custodial children at imminent risk of entering custody.
        2). The HST will be contacted when the Health Units cannot obtain necessary services from the MCO or BHO. The same process will be utilized as stated in Options for Out-of-Home Placements, Section IX.A.4.
        3). DCS will train its Child Protective Services staff on TennCare Access and Advocacy, including appeal rights under TennCare for non-custodial children. This training should inform workers of the appropriateness for utilizing the appeals process when the denial of medical and/or behavioral services threaten the inappropriate placement of children in custody.
    b. Family Preservation Services. The crises for some families, while directly related to the behavioral health condition of the child, may be more a deterioration of the family's ability to cope than a deterioration of the child's clinical condition. Therefore, the families which DCS considers will benefit from services modeled after Home Ties Program will receive these family support services, in addition to the targeted case management and covered BHO services. These will be deemed a carved out package of services provided through DCS different from services routinely provided by the BHO, and therefore, funding will be sought through TennCare if health related.
    c. DCS will develop and provide the following home-based services which may be begun prior to initiation of BHO services, and continued after BHO services are in place, if deemed appropriate by DCS to prevent custody. These will be provided for a period of ninety days. (However, if the child appears at "prolonged risk of custody", DCS can determine if the family/ caregiver wishes to continue these

services and if there is a desire to put the child in the carve-out MCO/BHO arrangement.)
The home based services include:

1. Intensive family preservation services which offer a short term, highly intensive home-based service designed to protect, treat and support families with a child at imminent risk of entering custody and that will enable the family to remain safely intact (Home Ties Model).
2. Utilization of a behavioral approach to teach all family members new skills so that they can more effectively manage their lives.
3. Formulation of a strengths-based, behaviorally specific assessment.
4. Support available to the family 24 hours a day, 7 days a week.
5. Less intense home-based intervention services to help families maintain the progress they made during family preservation services or to offer home-based intervention to children and families who can be successfully and safely provided with services that are less intense. Such programs will:
    a. Teach parenting skills and child development as well as age appropriate disciplinary techniques,
    b. Provide transportation as needed to access group therapy and other community resources, and
    c. Help families meet concrete needs.

X. PROCESS FOR RESOLVING SYSTEMIC ISSUES WITH THIS PLAN

If, in the course of implementation of this plan, the plaintiffs learn of problems that affect the delivery of health and behavioral health services to members of the plaintiff subclass and that appear to be of a systemic nature, the plaintiffs will inform the CSHN Steering Panel and Executive Oversight Committee of those problems. The CSHN Steering Panel will review the information submitted by the plaintiffs and make written recommendations to the Executive Oversight Committee regarding any actions that the CSHN Steering Panel believes should be taken to address the problem. If the problem threatens members of the

plaintiff subclass with immediate, irreparable harm, the plaintiffs may seek immediate relief from the Court. Otherwise, the plaintiffs will not seek relief from the Court as to that matter, until thirty days after the date on which the CSHN Steering Panel and Executive Oversight Committee were informed of these concerns. After thirty days have passed, the plaintiffs may, but are not required to, seek relief from the Court, and their further forbearance shall not be treated as a waiver in any subsequent judicial proceedings. The plaintiffs cannot seek relief from the Court in this case if the problem at issue is not of a systemic nature.

XI. RESERVATION OF RIGHTS

Consistent with Paragraphs 84-93 of the Consent Decree of March 11, 1998, children who are in or are at imminent risk of entering custody are entitled to the full protection of EPSDT law and the Consent Decree, in addition to rights afforded by other federal laws. The purpose of this plan is to ensure the protection and implementation of those rights and is in no way intended to supercede them. Specifically, in accordance with Paragraph 110 of the Consent Decree, the children who are the subject of this remedial plan shall not be deprived of any individual rights afforded by the laws which the plan is intended to implement.

TIME LINE FOR IMPLEMENTATION

Months from Entry by Court of
Revised Remedial Plan for Children in State Custody

Establish CSHN Steering Panel (completed)	
Implementation Team Established (completed)	
Establish Executive Oversight Committee (completed)	
Have contracts signed with Behavioral Health Referral Centers	3 months
Have BHRC fully staffed	6 months
Protocols/Best Practice Guidelines	
Physical Health (completed)	
Behavioral Health (have completed some components)	6 months
Training on Guidelines	6 months
Best Practice Network monitored for Best Practice Guidelines	24 months
Dental	
Use of local health departments with dental units (done)	
Expansion of local health departments capacity	6 to 12 Months
Pay additional screening rate	6 months
Submit to HCFA request to carve dental services out of TennCare	6 months
Best Practice Networks	
Current Network Identified/Gaps identified (done)	
PCPs recruited	6 months
Additional Private dental providers recruited	(6 months after Carve-Out Completed)
Transition from Custody Plan	
Implement Case Management	6 months
Panel established for determining children at "Prolonged Risk"	3 months
Protocol established for lengthening transition period	3 months
Advisory Group Evaluation of Recidivism	after 12 months experience and ongoing...
Needs Assessment	

Begun in July, Completed	6 months
Recommendations to Panel	8 months
Services for Children at Imminent Risk of Custody	
Health Services Team Assistance (done)	
Case management (done)	
In-home services (done in East Tn), completed by	12 months
Carve-Out of MCO and BHO	Children placed at the time of transition of all TennCare members are transitioned to new MCO's by end of June 2001.
Contract with Advocacy Group	4 months
Staffed and operational	4 to 8 months
Additional Mental Health providers placed in communities	6 to 12 months
DCS expands contracts for mental health professional	6 months

PLAN FOR CHILDREN AT SERIOUS RISK OF ENTERING STATE CUSTODY

The following modification to the Consent Decree is offered to avoid children coming into the custody of the Department of Children's Services due to a lack of needed behavioral services.

I. The following principles apply:

A. When these children come to the attention of DCS, DCS must have the ability to begin targeted case management and assure the provision of a clinical evaluation and the behavioral health services that are needed in a timely fashion (covered EPSDT services).

B. For these needed services to be effective, they must be: (a) timely, (b) include the comprehensive scope of behavioral health services to meet the identified needs of the child, (c) be community based whenever possible, so that they promote the lowest level of intensity that is clinically appropriate but also with consideration given to family and community ties being strengthened.

C. The method to fund these services should : (a) maximize federal funding and minimize state dollars, (b) strengthen the incentives of state contractors to perform according to contracts; (c) prevent duplicate payments.

II. The children eligible for this plan of services are TennCare eligible children who come to the attention of DCS (including through Child Protective Services) or the Health Services Team (including through referrals from the Advocacy Group contracted for outreach, information and referral services). Both DCS and the Health Service Team can determine eligibility according to:

A. Are the children in need of TennCare covered services:

B. Are the children not receiving necessary TennCare covered services; AND

C. As a result of not receiving TennCare covered services, are at a serious risk of entering state custody.

III. The services provided to this group of children will include:

A. OUTREACH, INFORMATION, REFERRAL, AND FAMILY CARE COORDINATION
In order to respond to the concerns of the Plaintiffs' attorneys that DCS should not have the sole discretion of determining who is at "serious risk" of coming into custody; to provide additional capacity to the system for all children needing behavioral health services; and to decrease the potential that children will come into custody to receive mental health services; the state will contract with an advocacy group that is able to provide these services for children. The contract will have the advocacy group provide the following services:

1. Staff a hotline throughout the state to have five or more offices with each office knowledgeable about the behavioral health services in its area as well as the process for enrolling in TennCare.
2. Provide outreach services to families with children needing behavioral health services; provide information about eligibility for TennCare and how children can be enrolled in TennCare;
3. Provide information to families about how to access behavioral health services and how to appeal services denied by insurers.
4. Refer children felt to be at serious risk of custody due to health needs to Health Services Team for designation of "at risk status" and eligibility of enhanced services to prevent custody
5. Serve as family service coordinators when a child has multiple providers or care-givers and parties need to be brought together to coordinate or integrate service for the sake of the child and family
6. Develop criteria for determining when children qualify for family

service coordination pursuant to this section.

7. Provide a representative to serve on Steering Panel.

B. MECHANISM TO GET TENNCARE SERVICES IN TIMELY MANNER

The Health Services Team within the Department of Health will have the authority to determine when children are at risk of custody as well as to authorize services denied by the BHO, or not provided in a timely manner.

1. Once the Health Services Team determines that a child is at risk of custody and is in need of behavioral health services, they can do the following:
   a. Determine if a service has been ordered, if not, arrange for the children to be seen and evaluated;
   b. Determine if the service ordered is medically necessary; if not, get the providers and BHO to agree upon what service is appropriate;
      If no agreement, the Health Services Team will decide but may consult with specialists before making the decision;
   c. Determine if BHO willing to approve the service ordered and needed;
      If, not, authorize the service, provide authorization letter to provider that the service will be reimbursed; file an appeal to determine who is responsible for the cost of the service – the BHO or the state.
   d. Make reports to TennCare and Executive Oversight Committee about the cases that are referred to them.

2. The Health Services Team will also request that DCS begin targeted case management and other services for children "at risk of state custody.

C. TARGETED CASE MANAGEMENT

1. DCS will develop and provide, through the Community Services Agencies, targeted case management for non-custodial children meeting the above criteria. DCS case managers, with support from regional Health Units, will access BHO services by referring cases to the BHO, advocating for appropriate services. When medically necessary services are denied by the BHO or delayed, DCS will notify the Health Services Team to intervene according to the process in III. B. 1. Any appeals filed for adverse action will be the responsibility of the Health Services Team.
2. DCS will train its Child Protective staff on TennCare Access and Advocacy, including appeal rights under TennCare for non-custodial children. This training should inform workers of the appropriateness of utilizing the Appeals process when the denial of medical and/or behavioral services threaten the inappropriate placement of children in custody.
3. The staff of the Advocacy group contracting with the state for outreach, information, referral and family case-coordination will also be trained on appeal rights under TennCare for non-custodial children.

D. FAMILY PRESERVATION SERVICES

1. The crisis for some families, while directly related to the behavioral health condition of the child, may be more a deterioration of the family's ability to cope than a deterioration of the child's clinical condition. Therefore, the families which DCS considers will benefit from services modeled after the Home Ties Program will receive these family support services in addition to the targeted case management and covered BHO services.
2. DCS will develop and provide the following home-based services which may be provided prior to initiation of BHO services, and continued after BHO services are in place if deemed appropriate by DCS to prevent custody for a period not to exceed 90 days.

a. Intensive family preservation services which offer a short term highly intensive home-based service designed to protect, treat and support families with a child(ren) at risk of custody and that will enable the family to remain safely intact (Home Ties Model).
   (1) Including utilization of a behavioral approach to teach all family members new skills so that they can more effectively manage their lives,
   (2) Formulate a strengths-based, behaviorally specific assessment,
   (3) Make support available to the family 24 hours a day, 7 days a week.

b. Less intense home-based intervention services to help families maintain the progress they made during family preservation services or to offer home-based intervention to children and families who can be successfully and safely provided with services that are less intense. Such programs will:
   (1) Teach parenting skills and child development as well as age appropriate disciplinary techniques,
   (2) Provide transportation as needed to access group therapy and other community resources,
   (3) Help families meet concrete needs.

E. BHO/MCO COVERED SERVICES

1. When a covered service has been requested by a health care provider, and the BHO/MCO has denied, or otherwise failed to provide that service in a timely fashion, the Health Service Team will be contacted for disposition:
   a. If the Health Services Team member determines that the MCO/BHO approved service is adequate then no change will be made. (If the service fails in the judgment of the DCS staff, the Health Services Team member can be contacted for a reassessment of the situation.)
   b. If the Health Services Team member agrees with the provider that a more intense service is needed, the HST will authorize the ordered service. Where practicable, the HST will utilize a qualified provider in the MCOs/BHOs network. However, a network provider will not be utilized if the Health Services Team, in the exercise of its sole discretion, determines any of the following:
      1) There is no time to locate a network provider under the circumstances,
      2) A network provider is not available to provide the services in a timely fashion,
      3) Available network providers are not qualified to deliver needed services, or
      4) Utilizing a network provider would otherwise jeopardize the health if the child in need of services.
   c. Whenever the Health Services Team authorizes the services under this provision, the HST will give the willing provider an authorization letter for services which will assure reimbursement, it will notify MCO/BHO of the decision, and will file an appeal. Should the decision on appeal be in favor of the MCO/BHO, the state will be responsible for reimbursement of those services. Should the decision be rendered against the MCO/BHO, the MCO/BHO will be assessed the cost of the service denied. However, the outcome of that process shall not affect the interests of the child, who shall receive the services in question without regard to whether the MCO/BHO or a state agency is ultimately determined to be financially responsible.

2. When a covered service has been requested by a health care provider (especially in the context of a juvenile court proceedings) and Health Services Team believes the service is not intense enough, the HST can

request a DCS mental health professional to provide a second opinion. If the second opinion differs from the service(s) originally ordered, the HST can request the BHO to cover the service(s) authorized by the second opinion. If the BHO denies the service(s) authorized by the second opinion, or otherwise fails to provide the service(s) in a timely fashion, then the HST can issue a letter of authority authorizing the service(s) in accordance with Section IX (A) (4). Where possible the HST should attempt resolving the matter with the BHO prior to issuing a letter of authority.

3 Therapeutic services provided may be any home and center-based services which are covered by the BHO.